

SELF REPORT OF EMOTIONAL EXPERIENCE, SEXUAL COGNITIONS
AND BEHAVIOUR DURING 100 DAYS OF A RELAPSE PREVENTION
TREATMENT PROGRAMME FOR CHILD MOLESTERS

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ABSTRACT

Fourteen men who were engaged in a Relapse Prevention treatment programme for child molesters filled out a self report form for one 100 days. The data collection time encompassed the cognitive distortions, sexual reconditioning and victim impact/empathy modules of the programme. The daily self report concerned their assessment of their emotional experience over the previous twenty-four hours, their sexual cognitions (fantasies and urges) and sexual behaviour. For these men there was no demonstrable relationship between their experiences of negative affect and sexual activity. The findings revealed that most of the men experienced shifts in negative mood, which was identifiable as occurring within modules and being in the "hotseat".

PART ONE

PART ONE

LITERATURE REVIEW

CHAPTER ONE: INTRODUCTION

OVERVIEW

The sexual abuse of children is an emotive subject. The widespread abuse of children has been described as the "best kept secret" (Rush, 1980). The prevalence and extent of child sexual abuse and its associated issues is, in particular, a phenomena of past 10-15 years. The feminist movement forced an awakening of interest in the problem (Marshall, Laws, & Barbaree, 1990) and brought the issues of domestic abuse, including the sexual assault of children into mainstream consciousness. Before that time it would seem that there was a collective denial of child abuse and its impact on victims (Miller, 1980). Coming to terms with these issues could be described as the major moral crises of our time and culture.

Until recently, reports of female perpetrated sexual abuse were seldom encountered in the literature. The few reported case studies conveyed the impression that female sexual abuse of children was so rare that it was almost unique in occurrence (Allen 1991). Although the focus of this research is the issues for "caught and incarcerated men", it is important to remember that women also sexually abuse children and a separatist approach (that is, its solely a male problem) will distort our delivery of an effective response, both to victims and offenders.

The costs of child sexual abuse, particularly in terms of the short- and long- term psychological, emotional and physical harm to victims, is incalculable. As a society we have started to respond actively rather than react passively to the issues of sexual abuse. In dealing with victims the Department of Social Welfare has made

the care and protection of children a priority through statute, policy and practice (Children and Young Persons Act, 1989). The resourcing of the Department of Social Welfare Specialist Services to provide evidential interviewing has meant that children are now able to disclose abuse in a safe and supportive environment. The New Zealand Police has trained personnel and developed specialist units to investigate abuse. In turn the Judiciary has recognised that the sexual abuse of children is a matter for significant penalty, one which reflects society's intolerance of this type of offending.

In dealing with offenders, it has become apparent that penalties handed down by Courts, including finite terms of imprisonment, do little or nothing to prevent further molestation. Recidivism statistics in New Zealand, for example, reveal that 25% of child sex offenders are back in jail for the same type of offences within five years (McLean & Rush, 1990). The establishment of the Kia Marama Specialist Treatment Unit, at Rolleston Prison, provides the most comprehensive intervention ever attempted in the Corrections Division of the Justice Department. The programme, which provides treatment exclusively for imprisoned child sex offenders was based in some measure on the work of Professor Bill Marshall, Queen's University, Ontario. Professor Marshall has been able to demonstrate a reduction in recidivism of about two thirds (Marshall & Barbaree 1988), and it is hoped that this success can be replicated in New Zealand. It is too soon to evaluate the long term success or otherwise of this programme, however early results are promising. (Hudson, Marshall, Johnston, Ward and Jones, 1994, in press).

A recent article by Quinsey, Harris, Rice, and Lalumiere (1993) challenged Marshall, Jones, Ward, Johnston, and Barbarees (1991) contention that treatment for sex offenders can subsequently reduce recidivism, on the grounds that they were not able to provide scientifically satisfactory answers to questions concerning treatment efficacy. In reply Marshall (1993), points to the ethical issues of developing a random treatment design for this population of offenders. Allocation to a non

treatment group, such as withholding treatment, has severe implications when the instance of even one reoccurrence of the behaviour means another victimised child. The Atascadero Programme, (Marques et al) does have random assignment to treatment and control groups, but this is unusual in the management of sexual offenders within the treatment field. Marshall contends, that it is good science to apply rigorous methodological standards to a well developed field but it is poor science to demand such standards as the only basis for inference in a field that is in its early stages, but is rapidly developing.

PHILOSOPHY OF TREATMENT

As professionals have improved their capacity to deliver effective interventions to men who sexually abuse, it has been generally supported that those who work in this field should have a common philosophy of treatment. The need for a common philosophy is predicated on the knowledge that the sexual abuse of children, is a covert act carried out in a web of denial, distortion and sexual deviancy. A common philosophy of practice will ensure that professionals respond in a consistent, clear and competent manner to the issues, of child sexual abuse.

The following philosophy is taken from Anna Salter's. "Treating Child Sex Offenders and Victims; a practical guide", which states;

Child molestation is either the result of either a deviant arousal pattern and/or the inappropriate conversion of non sexual problems into sexual behaviour.

The goals of therapy are as follows: a) for offenders is to learn to control their deviant arousal patterns, b) to place obstacles in the path of converting non sexual problems into sexual behaviour.

A third goal of therapy is for offenders and their families to learn to solve nonsexual problems in non sexual ways. For example, the offenders need to deal with marital

problems, depression and other life problems directly, without the use of inappropriate sexual acting out.

Offenders must take responsibility for child sexual abuse without minimising externalising or projecting blame onto others. Manipulation and denial are major behavioural overlays of the offence and response to discovery. Each parent must take responsibility for his or her own behaviour and not the others. Spouses are responsible for the abuse if they are involved in sexual abuse. They are responsible for denying and minimising if they do so.

Child sexual abuse is a treatable problem. Treatable is defined as helping the offender learn ways of minimising the risk of re-offence; it does not mean cure. Any dysfunctional family patterns resulting from or providing the opportunity for sexual abuse need to be addressed and changed. These may include but are not restricted to isolation, poor communication, lack of boundaries and patriarchal entitlement. (Salter, 1988)

Victims are not responsible for child sexual abuse under any circumstances. The key issue is consent; for consent truly to occur, two conditions must prevail. A person must know what it is that he or she is consenting to and must have true freedom to say yes or no (Finkelhor, 1984). A child is not able to comprehend adult sexual intimacy or the socio cultural rules that surround it and so is not able to consent under any circumstances.

CHAPTER TWO

ETIOLOGY OF THE SEXUAL ABUSE OF CHILDREN

OVERVIEW

The theory about why people behave in a certain manner determines what type of response is developed by the persons in society who take up this task. Traditionally, a mixture of folklore and theory was adopted by those in the helping professions when dealing with the issues of sexual abuse. Prior to the 1970's very little was known about sex offenders at least partly, because public and scientific awareness of this problem was minimal (Marshall, Laws and Barbaree, 1990). In recent years a shift in the focus of both theoretical and research issues concerning sexual violence, including the sexual abuse of children, has been observed in the scientific community (Darke, 1990). This changed emphasis can be linked to the the feminist movement and the early writings of such women as Brownmiller (1975). Previously considered essentially sexual in nature, the change in emphasis focused attention on the nonsexual needs that were served by sexual assault, such as the need for power and control (Darke, 1990).

When dealing with the issues of sexual offenders it becomes immediately apparent that they are not a homogeneous group. Their issues range from the fixated offender who is a member of a pedophilic organisation and considers that he is the victim of society's intolerance and naivety, to the person who has started sexually abusing his daughter or son, but will not admit this fact even to himself.

Modern theories of offending generally take a cognitive-behavioural approach which conceptualises sexual abuse of children as a multidetermined phenomena (Marshall & Barbaree, 1990, Araj & Finklehor 1986). Such areas as the development of deviant sexual interest, the associated lack of appropriate inhibitors (Laws & Marshall, 1990), deficits in social learning, sociocultural development and

dysfunctional interpersonal styles are targetted in treatment. These vulnerability factors interact with more transient situational elements such as intoxication, strong negative affect, a belief that he will not be caught, and the presence of a potential victim to determine the occurrence of a sexual assault (Marshall & Barbaree, 1990).

These factors can be broken into two categories those which are proximal that is, able to be identified, at the time of offending; and distal that is, those lifetime experiences which have influenced the attitudes, beliefs and behavioural repertoire of an individual.

DISTAL ETIOLOGICAL FEATURES

Early Development

These men appear alienated and they typically have a history of emotional isolation from others. One of the key needs met in Bowlby's (1973) attachment theory is the need for intimacy. The failure to achieve intimacy has its roots in erratic and rejecting parenting behaviours, which alienates children from the possibility of forming secure attachment bonds. Such early developmental experiences distinguish the family contexts in which sexual offenders grow up (Marshall & Barbaree, 1984).

The bond which is most specifically discussed in this theory is attachment to the mother, infants are described as securely attached, anxious/ambivalent and avoidant. However the nature of attachment to the father may be equally important in terms of socio cultural development, especially when father/daughter, mother/son relationships are taken into account.

The development of an avoidant or ambivalent bond between mother and child has been associated with extremes of negative emotion such as anxiety or anger such

as is described in the psychoanalytic literature of cathartic reactions and persons being immobilised by fear. The implications for individual who have not been able to achieve secure attachment is the tendency to view the the world as a hostile and frightening place where one must be constantly on ones guard and mistrustful of others in order to survive.

One of the common themes in the literature concerning the non sexual needs that may be met through the sexual assault of children is the need for power and control (Darke, 1990, Howells, 1977). Relating to a child does not bring with it the challenge of developing adult-adult mutuality in social relationships.

Research which investigated the experiences of childhood abuse of men in therapy at Kia Marama indicated that 70% of the men had been abused themselves in childhood, 40% of that number by women (Robertson, 1990).

Elsewhere in the literature, the percentages of incestuous fathers who were sexually abused as children is reported as 35% (Baker 1985), and the mean about 20%.

These numbers are closer to estimates of the rate of sexual abuse in the community. This suggests that there is much more to sexual abuse than simply "intergenerational transmission". Rates of physical abuse in the backgrounds of incestuous fathers ran consistently higher than rates of sexual abuse.

Puberty

The transition from parental attachment to peer attachment and the associated capacity for adult intimacy, is dependent upon adolescent experiences. In these formative experiences the parents play a vital role in providing a warm supportive attachment figure, in instilling self confidence so the transition to adult intimacy is facilitated, and in providing the skills necessary to act effectively on the need for intimacy (Marshall 1989). The process of relinquishing parents as attachment figures can be disrupted by parental behaviour, such as discouragement of the

adolescent forming attachments outside the family e.g. making the adolescent guilty about drawing away from the family. A way that this might occur is non acceptance of an adolescents peers.

During adolescence there are many influences on the individuals development. Marshall (1989) points to the socio cultural influences which shape attachment behaviour such as the media messages which diminish the value and nature of adult relationships (the typical lonely hero in Western movies). The content of popular music and videos which contain messages that male-female relationships are adversarial and punishing, also provides a significant influence on adolescents world views.

Becker and Stein (1991) stress the influence of the first "real" sexual experience for adolescents and the reinforcing nature of the circumstances surrounding it. Their study involved 160 males with a mean age of 15.4 who had been charged with sexual assault. Most of their victims were female, less than 8 years of age. Their findings revealed that: a) magazines and videos were the sexually explicit material most often used; b) those offenders who consumed alcohol had the highest number of victims and those who said alcohol increased arousal had the most victims; c) those offenders who had been sexually abused had more victims than offenders with no history of sexual victimisation; d) those who had been physically abused had more victims, and e) most subjects reported that sexually explicit material played no part in their offending. The conditioning theory of sexuality, outlined in a later section would take issue with this last point, however the subjects may have no insight into the disinhibiting influence of hard core pornography.

Marshall and Barbaree (1990) consider that the acquisition of attitudes and beliefs during childhood sets the stage for the developing male to respond to the onset of strong desires characteristic of pubescence with a prosocial or antisocial mindset and the task for the human male is to acquire inhibitory controls over a biologically

endowed tendency to fuse sex and aggression.

Socio-Cultural Development

Social competence involves a matrix of component skills in the interpersonal (empathy, assertiveness, anger and anxiety management, and conversational skills) and relationship domains (particularly communication, conflict resolution and intimacy skills). Sex offenders have been shown to be deficient in recognising emotions in others (Hudson, Wales, Bakker, McLean and Marshall, 1991) and they lack empathy (Finklehor, 1984). They are also less assertive (Segal & Marshall, 1985), more socially anxious (Gordon, Weisman, & Marshall, 1980) and less skilled in conversations (Stermac, Segal, & Gillis, 1990) than other men. It has recently been found that rapists, child molesters, and exhibitionists are socially lonely and lack intimacy in their lives (Marshall, W.L., Jones, R., Hudson, S.M., McDonald, E., In Press).

Adult Sexual Functioning

A pedophilic-type sexual orientation is characterised not simply by arousal to children but also by disinterest in, disgust at, or conflict over sexual relations with adults. Marshall (1989) suggests that the failure to achieve intimacy in relations with adults produces emotional loneliness which in combination with other determinants sets up a vulnerability to offend. The construct of intimacy is conceptualised as lying along continua with deep intimacy at one end and emotional alienation at the other. The ability to experience empathy is also considered necessary, to fully share the emotional issues relevant to their partners (Marshall & Barbaree 1989). Concerning the issues of interpersonal intimacy Marshall (1989) reports that a significant number of offenders appear to have numerous social contacts and apparently effective marriages, although most of them report these relationships to be superficial and their partners to be more like acquaintances than intimate and supportive

companions. While many of these men report reasonably frequent sexual relations with their partners, they nevertheless claim that such sexual relations are unsatisfying although they often cannot say why.

Development of Deviant Sexual Interest

Sexually aggressive behaviour appears to be multiply determined (Marshall and Barbaree, 1990). It is likely that the physical substrate supports the ready capacity to sexually aggress (Marshall 1984), and between individuals, variations in hormonal functioning potentiate this (Bradford, 1990).

Marshall and Eccles (1991) review of the literature concluded that for all types of sex offenders, the belief that deviant sexual preferences are fundamental is not supported.

Among child molesters, there were more men who revealed deviant preferences, but even here less than 50% were either equally or more aroused by children or adults (Barbaree & Marshall, 1986; Marshall, Barbaree, & Butt, 1988; Marshall, Barbaree, & Christophe, 1986). However, since some offenders do display deviant arousal, and since all of them are prompted to act in a sexually deviant manner, it is necessary to implement procedures to reduce these tendencies whether or not they appear as aberrant in laboratory assessment.

Quinsey and Marshall (1983) have observed " We simply do not know how to account for individual differences in sexual arousal patterns" and suggest that developmental studies regarding the acquisition of sexual preferences should receive high priority.

Laws and Marshall (1990) have developed a theoretical model which describes how a person could develop deviant sexual preferences (e.g interest, arousal, attraction,

orientation) which are often assumed to drive deviant sexual behaviour. They caution against using this theory to account to explain deviant sexual behaviour of those offenders who do not have deviant sexual interests.

The model is divided into two parts (1) acquisition processes and (2) maintenance processes. They describe ten fundamental principles which underly how a deviant arousal pattern may be developed through pavlovian and operant conditioning, the role of extinction, punishment and differential consequences. A significant construct described in this paper is "preparedness" (Seligman, 1970). This describes how some stimuli and events are more likely to be associated with sexual arousal and these are more likely to be incorporated into an individual's developing repertoire.

Given its high survival value for the species we would expect humans to be highly prepared to acquire sexual responses to opposite sex partners. Age inappropriate partners and forced sex would also be well prepared responses along that continuum especially for individuals who are less able to compete for consenting adult partners. Seligman (1971) predicts that some associations, in this case sexual responses, (1) can be acquired in one or two trials, (2) are highly selective and specific to the stimulus, (3) are highly resistant to extinction, and are non cognitive (i.e., primitive) and not readily modifiable by information. This account offers an explanation why deviant sexual behaviour is so resistant to modification.

The maintenance principles they describe point to the role of fantasy and pornography paired with masturbation. Also the resistance to extinction of intermittent reinforcement. The implication of this treatise concerning the conditioning process, is that once acquired deviant sexual behaviour becomes part of an individual's behavioural repertoire, and may be strengthened through reinforcement. Reinforcement not only includes participating in the behaviour, other potent reinforcers incorporate the use of fantasies and pornography coupled with masturbation. The self reported frequency of externally provoked sexual thoughts,

(urges), and internally generated sexual thoughts (fantasies), in a non deviant population has been described by Jones and Barlow (1990) 71% of men reported becoming aroused by sexual thinking on a daily basis, and the remainder of the sample population fell in to the next category of twice a week or so, this can be compared to 78% of the women i.e identifying as belonging to the first two categories. This study also reported the existence of high levels of sexual thoughts that did not lead to arousal. In this sample of 50 men and 50 women, nearly half of the women and 16% of the men reported never masturbating. None of the sample reported masturbating on a daily basis.

The largest category, by gender, reporting being twice a week for males, (26.5%) and less than once a month for females, (25.5%). The distinction of Jones and Barlow between internally generated versus externally provoked cognitions may have implication for treating incarcerated sexual offenders. Their experience whilst imprisoned, away from their chosen environment, may well be devoid of the externally provoked urges towards offending and this have implications for future risk.

PROXIMAL

Arguably, the most cogent model of proximal factors, in terms of Psychological Theory, is that developed by Pithers, Marcus, Gibat and Marlatt (1983), using the Relapse Prevention model from theory of addictive behaviour.

The proximal features of offending can be conceptualised in terms of the Relapse Prevention model of offending behaviour, which is articulated in greater detail in later parts of this thesis. The Relapse process comprises a cognitive-affective-behavioural chain that begins with managing Lifestyle Balance and Stressors (Thompson; 1989), the failure to do so makes an individual vulnerable to making Seemingly Irrelevant Choices (Jenkins-Hall & Marlatt; 1989), which leads him into a High Risk Situations (Marques & Nelson; in Laws 1989), the Problem of Immediate Gratification (Marlatt,; in Laws 1989) can lead to approach behaviour, a Lapse, the

Abstinence Violation Effect (Russell, Sturgeon, Miner & Nelson: in Laws 1989) and Relapse into offending behaviour. The Relapse model will be discussed in further detail later in this review.

In a study which examined the precursors of sexual offending, Pithers, Cumming, Beal, Young, & Turner (1989) determined a common sequence of behaviours comprised the relapse process. The first change in the clients functioning was affective, they referred to themselves as "lonely" and "confused". Typically they found themselves unable to deal effectively with their emotional states and then began using deviant fantasies as a means of coping, The development of these fantasies contributes to the passive planning of sexually abusive behavior.

Offenders find themselves developing rationalisations for their intended actions through distorted cognitions e.g attributing adult characteristics to children. Two linking psychological mechanisms are thought to operate the Problem of Immediate Gratification (P I G) and the Abstinence Violation Effect (A V E). The first is the short term gratification that a person might gain out of offending e.g sexual gratification and the second is the persons internalised view of their own ability to control their behaviour and the consequences of breaking their own rules, its not a problem, I'm not doing any harm. (See Appendix for digrammatic depiction of RP model).

Pithers, Kashima, Cumming, Beal and Buell (1987, 1988) review of the antecedents of sexual assault found that more than half of sexual offenders were emotionally overcontrolled. These men left hostile interactions without expressing affect, and as they brooded about the incident over time their rage grew. Some offenders harboured rage about a single event for a decade, continual augmentation of the emotion lead to to an explosive assault later in time, which was far removed from the instigating event. A similar process with anxiety and depression was noted.

SUMMARY

In order to develop a comprehensive model of sexual offending, both proximal and distal etiological factors must be taken into account. These factors operate in concert to predispose some individuals towards sexually abusive behaviour. The distal features include negative developmental experiences, the failure to deal with the challenges of puberty, adult life and socio cultural conditioning. The proximal factors involve deficits in coping skills to manage emotional states, sexual urges, stressors and lifestyle balance.

CHAPTER THREE

TREATMENT INTERVENTIONS

OVERVIEW

The covert nature of child sexual offending and the levels of denial maintained by individuals identified as child sex offenders has meant that up until the last decade the demand for treatment was limited to those identified by the authorities; self-referral was rare. Getting offenders into treatment continues to be a problem for social workers, lawyers, mental health professionals and probation officers, and the social systems of the offenders than those individuals .

The development of the etiological model has meant that it has been possible to develop treatment interventions which address the issues for sexual offenders. In their review of the literature, Gendreau and Andrews, (1990) considered effective treatment for specific offender groups such as substance abusers and sex offenders. Their recommendations include: delivery of intensive treatment for those at medium to high risk of re-offending; the development of interventions that are behavioural in

nature with a focus on cognitive and skill building strategies; also the emphasis of therapy targetting the attitudes, values and beliefs that support the anti social behaviour.

Interventions

Early attempts at developing interventions for child sex offenders tended to focus on one aspect of the men's sexually abusive behaviour. In their review of the literature, Marshall, Jones, Ward, Johnston and Barbaree (1991) report three physical treatments; Psychosurgery, involves the ablation of a specific part of the brain, (typically hypothalamotomies). The leading advocates are a group of German surgeons. The outcome of treatment does not appear to be that successful, and there are ethical questions about this procedure (Valenstein, 1973); Castration seems to yield excellent recidivism rates, Sturup (1986). However there is some suggestion that castrates may reoffend in nonsexual ways at higher rates. Given the social cost of implementing this procedure it is unlikely that it will be employed outside of Europe; Pharmacologic interventions are used by the medical profession is the suppression of the sexual drive using anti androgens. Unfortunately this method of treatment concentrates only on the symptoms and does not assist the individual to assume control over his behaviour. It is important to keep this in mind when implementing this intervention otherwise there is a real danger that an offender will refuse responsibility for his sexually assaultive behaviour because of the failure of medication. However, there is no doubt of the utility of antiandrogen medication as an adjunct to Psychological intervention (Marshall et al.).

Cognitive Behaviour

Cognitive-behavioral treatment programmes assume that sexual offending reflects at least some degree of sexual attraction to inappropriate partners or acts, often associated with a relative lack of appropriate arousal. These inappropriate arousal

patterns and deviant sexual acts produce a broad range of cognitive distortions that serve to rationalise the antisocial behaviours. Many offenders also display deficits in social competence and daily living skills, which restricts access to appropriate partners and cause stress, which in turn increases the probability that the sexually deviant behaviour will occur. The major aims therefore of treatment predicated on a cognitive behavioural perspective are to eliminate cognitive distortions, normalise sexual preferences, enhance social functioning, and improve life management skills. Over recent years additional components have been added to behavioural programmes that make the goal of Relapse Prevention more explicit. These components were derived from Marlatt and Gordon's (1985) work on Relapse Prevention (RP) in the addiction field, which are summarised in the following section.

CHAPTER FOUR

RELAPSE PROVENTION

OVERVIEW

RP model was initially developed as a maintenance program for use in the treatment of alcohol abuse, cigarette smoking, drug abuse and overeating (Marlatt & Gordon, 1980).

For the addictions, abstinence in drug abuse, or regulatory control for eating disorders are the goals. The chief emphasis has been on getting the "addicted" person to stop engaging in the problematic behaviour. High relapse rates in addiction treatment has shown that "getting stopped" gives no assurance of remaining stopped. All too often posttreatment changes eventually give way to the pretreatment addictive pattern.

Conceptual Framework And Theoretical Underpinings

George and Marlatt (1989) state that the underpinnings of the RP programme derive from the broader social learning (Bandura, 1969, 1977a) approach to understanding human behaviour, now referred to as social cognitive theory (Bandura, 1986). RP combines both behavioural and cognitive interventions and as such makes critical assumptions about addictive disorders. First, addictive behaviour patterns are viewed as multidetermined by past learning experiences, situational antecedent influences, prevailing reinforcement contingencies (both rewards and punishments), cognitive expectations or beliefs, and biological influences. Second, the target behaviour can best be construed on a continuum from nonproblematic expression (e.g. social drinking) and addictive or problematic expression (e.g. alcoholism). Finally the the addictive behaviour can be conceptualised as a maladaptive response for coping with life stressors and dissatisfactions. The implication being that the individual habitually chooses not to employ more adaptive coping responses.

It is important that it is made explicit that RP as conceptualised above is separated out from the more predominant theoretical model in the addictions field, loosely known as the medical disease model. The RP programme described here is not an outgrowth of the medical disease model of addictions and thus does not define addictions as disease entities.

The RP model comes from social learning roots, the emphasis is on self management. As such, RP exemplifies the compensatory model for helping coping described by Brickman et al (1982) in which clients are not seen as responsible for problem etiology but for problem solution. According to Brickman et al., interventions that minimise client responsibility for problem solutions tend to foster dependency, undermine client feelings of personal competence, and generate

improvements that are attributed to external forces and only temporarily maintained.

In the addictions field, habit change is conceptualised as a multistage process. Individuals may be more amenable or receptive to particular interventions at different stages of change. The five stage model, based on work with cigarette smokers, proposed by Prochaska and DiClemente (1992), (Prochaska, J.O., DiClemente, C.C., Norcross J.C., 1992) is considered the most thorough and empirically cogent multistage model. For the purposes of this thesis a two stage model will be described; the therapeutic intervention and the maintenance programme. Once conceptualised in this manner it is possible to separate maintenance failure from treatment failure. When this does not occur the general trend is to create a treatment so powerful that it would be less prone to "wear off". The addition of more techniques makes it more difficult for the client to comply with treatment requirements (Hall, 1980). A good example of this is the tendency to extend the length of treatment.

Relapse Prevention is predicated on the assumption that the individual has voluntarily chosen to adopt a rule or set of rules for changing the addictive behaviour. The individual has perceived control over the behaviour until a high-risk situation (HRS) is encountered. An HRS can be broadly defined as any situation that poses a threat to perceived control and thereby increases the possibility of lapse or relapse (i.e. violation of self imposed rule set).

Available research findings have suggested that certain types of events prototypically represent HRSs that can predispose individuals towards relapse. For example, Cummings, Gordon and Marlatt (1980) found that 71% of all relapses studied across various addictions were precipitated by one of three types of determinants: 1) negative emotional states (35%), or situations where person experienced unpleasant emotions or feelings (e.g. anger, boredom, depression) that were not occasioned by another individual; 2) interpersonal conflict (16%), or

situations in which the individual recently engaged in an argument or other unpleasant interpersonal confrontation; and 3) social pressure (20%), or situations in which the individual experienced direct or indirect pressure from others to violate the rule set.

Such data refuted the traditional view that relapse was determined entirely by internal physiological phenomena (e.g. urges). The RP model hypothesises that the likelihood of relapse depends on the individual's ability to cope with HRSs. If a person fails to cope with a HRS then relapse becomes more probable.

Sex Offending As An Addictive Disorder

Parallels between sex offending and addictive disorders are easily drawn. This would seem a convincing reason to apply RP to sex offending but it is not the predominant rationale. The applicability of the RP model for working with sex offenders is justified primarily on the grounds that recidivism can easily be conceptualised as a maintenance problem. (George & Marlatt, 1989). A word of caution from Pithers (in Marshall, Laws & Barbaree, 1990) is that he has discovered in his work that the highly cognitive strategies of RP can heighten an offender's intellectualised defences about recognising the harm inflicted upon victims. Empathy, for victims, represents a critical source of motivation for the offender's treatment and maintenance (Hilderbran & Pithers, 1989). In order to avoid RP being viewed by offenders as an interesting intellectual exercise having little relevance to their lives, it is introduced only after victim empathy has developed.

Sex offending as an addiction has been popularised by Carnes (1983) who argues that sexual activity can become as addictive as alcohol or other drugs. He loosely defines sexual addiction as a "pathological relationship to a mood altering experience". Carnes' approach conceptualises sex offending as an illness like alcoholism and recommends a twelve step programme much like AA. Hence self

help groups have appeared: Sexual Addicts Anonymous, Sexaholics Anonymous, Sexual Abuse Anonymous and so forth. This type of conceptualisation; the "addict's" admission of powerlessness, places the locus of responsibility for the offence pattern and treatment outside the offender, whereas a key tenet of RP is that the individual must take responsibility for how he chooses to behave in the world.

Similarities Between Sex Offending And Other Addictions

Both syndromes are associated with high cost for the individual and society. In both phenomena, there is an emphasis on immediate short term gratification, at the expense of delayed, long term negative consequences. As Carnes (1983) suggests, compulsive sexual activity, offers the allure of being a reliable mood-altering experience. There appears to be a compulsive as well as impulsive quality to both types of activities.

For example, in the case of sex offending offenders report having committed many more offences than are revealed by their official records (e.g. Abel et al., 1987). The treatment lore depicts sex offenders and addicts as being particularly prone to denying the target behaviour as problematic and to surrounding the behaviour with secrecy. It has been documented that relapse episodes for sexual offending (Pithers, Marques, Gigat, & Marlatt, 1983) and other addictions (Marlatt & Gordon, 1980) are characterised by similar types of precipitants, especially negative mood states. Furthermore, sex offending has unique similarities to gambling, an addiction not involving ingestion of a substance and to overeating, an addiction for which a total- abstinence treatment goal is untenable.

Differences Between Sex Offending And Other Addictions

The above similarities notwithstanding, important differences exist between sex

offending and addictive disorders

The fact that each offending occurrence has significant impact on a victim is a difference which must be emphatically drawn. Although the consequences for an individual and their family may be truly distressing when a person relapses into alcoholic drinking, this incidence does not have the impact on another individual as relapsing into sexually abusive behaviors such as sexual violation. It is essential that this distinction is made or there is a danger of trivialising the reoccurrence of "target behaviours".

Ethical considerations must also be taken into account when considering sex offending in contrast to addictive disorders. The offender who reoffends has not only relapsed he has broken the law. Even with addictions that are illegal, such as heroin use, the ramifications are not the same for those therapists as the issues of interpersonal violence are much more serious.

The role of fantasy is another difference between sex offending and addictions. With all addictive disorders, the individual may dream or fantasise about engaging in the behaviour. However, fantasies play a much more potent and crucial role in the life of a sex offender (e.g. Marshall & Laws). First, the discrepancy between the gratification obtainable from the fantasy versus that attainable from actual indulgence in the target behaviour (the sex offence) is less dramatic than with most addictions. This is true because the offenders' fantasy will very likely be accompanied by genital arousal, which is typically experienced as pleasant and reinforcing in its own right. In fact the offender can employ physical aids such as pornography to heighten the arousal achieved from the fantasies. Second the gratification level associated with the fantasy can readily be maximised when augmented by masturbation and orgasm. Third, many sex offenders report that active and deliberate fantasising about the offence is an integral part of the

preoffence sequence. Fourth, because of the foregoing features, the offenders attachment to the offence pattern can be sustained during periods of externally imposed abstinence, such as incarceration.

Instances of lapse and relapse are clearly discernable and definable with addictive disorders. With sex offences there is a moral and ethical problem defining lapse as one incidence of the target behaviour, given that this would mean the molestation of a child. In the Relapse model for sex offenders lapse is defined as an approach behaviour.

CHAPTER FIVE

TREATMENT

KIA MARAMA THERAPY PROGRAMME

This group based intervention targets the behavioural, cognitive and affective functioning of men in prison who sexually abuse children. Referrals are made by Corrections Psychologists. The intake criteria is as follows: 1) The inmate has committed one or more sexual offences against a person under the age of 16 years, these need not be the person's current conviction, nor, need he ever have been formally convicted of such an offence; 2) The inmate is informed about and voluntarily consents to enter treatment, persons are not excluded if they are exhibiting forms of denial; 3) The person has sufficient length of sentence to complete treatment; 4) The person is intellectually able to comprehend and participate in group treatment; 5) Is currently free of any major psychotic disorder; and 6) Does not require maximum security classification.

Inmates attend treatment in a purpose built wing of Rolleston Prison for eight and a half months. The programme is split up into modules of around a months duration

(i.e. four days a week 2 1/2 hours a day). The aim of each module in the programme is to assist the men to take responsibility for their offending, develop empathy for their victims and for them to be able to articulate their Relapse Process.

When Men come to therapy they are offered an opportunity to make changes in their lives through challenging their own attitudes and beliefs, social conditioning and interpersonal style of interacting with others.

There are three definite phases of the programme.

1) The first section including cognitive distortions, sexual reconditioning and victim impact/empathy is perhaps the most challenging time in the programme. During these modules, the men address the proximal issues of their offending, how they rationalised their offending to themselves and what impact their sexually abusive behaviour had on their victims. The sexual reconditioning module asks the men in therapy to acknowledge their deviant sexual fantasies and implement a reconditioning technique. It must be stressed that denial is the problem to be treated in child sex abuse, for men to openly acknowledge these issues to themselves, their therapist and then the other men in the therapy group is a challenge for all concerned. The experience of being in the "hotseat", where the individual's issues are the focus of the group is particularly stressful.

2) The second phase of the programme addresses issues of social competence and mood management. The emphasis of this section of the programme is education and skills building. The modules in this section of the programme include: relationship skills, sexuality education, anger management, stress management and social problem solving.

3) The last part of the programme, relapse prevention, focuses on equipping the men

with strategies which will enable them to manage a non offending lifestyle. They are taught the components of the relapse model and asked to identify their seemingly irrelevant choices, high risk situations and offence precursors. They are asked to develop a personal statement which articulates their specific relapse issues. This includes acceptance of responsibility for offending, acknowledgement of harm to victims, future high risk situations, plus the coping strategies which have been learnt in the programme which will assist the offender to maintain control over his behaviour. Again, the emphasis is control, not cure.

PROGRAMME

Assessment

Each man is assigned to a group with up to nine others and a therapist. This group then stays together through the entire programme. The men start the programme with a month of assessment which investigates;

- a) Sexual behaviour: sexual preference, adult sexual competence, sexual attitudes and beliefs, and fantasy;
- b) Social competence: interpersonal and relationship skills, problem solving ability, capacity for intimacy, self esteem, mood management skills; and
- c) Cognitions: attitudes towards women, beliefs about sex with children, harm to victims, etc.

Three sources of information are gathered during assessment; individual interviews, psychological scales and questionnaires, and plethysmographic assessment.

Modules

Introduction: The first week of the programme is set aside for norm building, which facilitates the development of appropriate norms that are conducive to productive group work and the therapeutic change, another aim is to develop a sense of group cohesiveness. The following two weeks are set aside to explore men's own victimisation issues. The aim is to diminish the negative impact of men's own abuse experiences upon their current emotional and interpersonal functioning, and to enhance men's capacity to subsequently experience empathy for their own victims.

Cognitive Distortions: The aim of this module is to enable each man to fully understand his relapse cycle, to recognise and understand the features in his life that motivate and maintain his offending behaviour. Also to encourage the development of appropriate attitudes and beliefs regarding sexual involvement with children, and facilitate the adoption of a sense of responsibility for both past offending and the avoidance of future offending. It is expected that recognition of these issues will build motivation for and commitment to fully engage in the treatment programme. Each man is required to develop his own relapse cycle, then present and discuss it with the group. As he does so, the therapist (and other group members) challenge and confront distortions, such as minimisation, or evasion of responsibility, by the man. The goal is for each man to acknowledge the true extent of his offending history, and to develop a thorough understanding of the issues in his life that served to motivate and maintain it.

Sexual Reconditioning: The aim of this two week module is to reduce and/or eliminate the sexually arousing effects of deviant (child) sexual fantasies, and to increase the strength of sexual interest in adult partners. Once learned, the men are expected to intensively practice these techniques outside of group time. The procedures used include covert sensitisation, orgasmic reconditioning and verbal satiation. These procedures are introduced at this stage of the programme and each man is expected to thereafter practice the techniques weekly throughout the remainder of his time in treatment.

Victim Impact/ Empathy: This module aims to educate offenders regarding the impact of sexual abuse upon victims generally, and specifically to assist them to identify the harmful consequences of their offending behaviour on their own victims. The men are challenged to accept responsibility for having created this harm and also helps them to take victim's perspective of the abuse.

The second aspect of this module and one, considered necessary to build motivation for achieve a non offending lifestyle is for offenders to develop an emotional sense of empathic concern, both for sexually abused victims generally, and their own victims in particular.

Relationship Skills: The following module is a shift in focus towards skills aquisition, understanding the meaning and value of achieving intimacy in an adult-adult relationship.

Sexuality Education: The aim of this module is to develop a broader and more accurate knowledge of sexuality, increase the level of comfort in discussing sexual matters, and to reduce levels of anxiety arising from misinformation and unhelpful attitudes. It also educates the men to adopt attitudes appropriate and conducive to respectful, consenting and mutually rewarding sexual intimacy with an adult partner.

Mood Management: This module aims to recognise and adaptively manage a range of emotions, especially anger, anxiety/stress, sadness/depression. It also allows them to be able to identify environmental, cognitive and physiological components and triggers for each of these emotions. Further aims, are to identify particular emotions which have been difficult to manage in the past especially those that have been associated with offending cycle.

Relapse Prevention: The men are expected to clearly articulate a "personal statement" based on an understanding of his relapse process, and a willingness to share this information with significant others. Finally it aims to develop a commitment to a lifelong plan to avoid future offending.

Relapse Process and Negative Mood States

Marshall, Hudson and Ward (1992) describe the Relapse process as a chain of responses that include affect, cognitions and behaviours. Research has demonstrated that negative affective states, deviant sexual fantasies and planning present three major characteristics of the proximal features of offending behaviour.

(Pithers, Kashima, Cumming, Beal & Buell, 1987, 1988). In some instances negative emotional state may trigger the sequence; in others it may be a thought or a behaviour that initiates the chain leading to relapse. The types of emotional responses that may start the Relapse process are many, varied and typically idiosyncratic. For example one offender may respond to arguments with his partner by becoming angry, and his dysfunctional way of coping with his anger is to sexually assault: that is, fusing sex and aggression. For another arguments may make him depressed, in order to cope he may look for sexual gratification through sexually abusing a child. Other emotional states that typically trigger a Relapse include loneliness, boredom, anxiety or confusion. One particularly salient emotion is a feeling of deprivation. This may result from unsatisfactory relations with a partner or it may arise when a person feels they are carrying too many responsibilities. In each case these negative emotions lead to rationalising processes, which justify deviant sexual fantasizing and lead to planning and executing a deviant act.

In treatment, the offender must identify the emotions and cognitions that typically lead to the initiation of the Relapse chain. He must then learn relevant coping skills

(e.g. anger management, relaxation training, problem solving, thought stopping, distraction etc.) which he can then use in the future. The men are taught each aspect of the Relapse Prevention model in depth and the relevant coping skills for each step.

Clinical Issues For Men In Treatment

People in therapy often experience a great deal of fear when asked to attend to unpleasant emotions. When delivering a therapy programme to child sex offenders McDonald and Pithers (1990) report that men seldom expressed this fear but more often express an angry resistance, a blustering insistence that they do not have those feelings, or a more passive stance of confusion or inability to remember emotions. The reasons for that fear are easily understood after even a cursory review of an offenders history many offenders come from extremely chaotic, dysfunctional families where the expression of emotion was distorted and often used coercively. Offenders with this background view emotions with fear, for they have witnessed them as weapons of manipulation. Negative emotional states may be constant for them, leaving them unable to discriminate any change in their emotional state. For other offenders "normal" may have been defined as having everything, including emotions, tightly under control. For these individuals any emotion is frightening, for they have equated affect with chaos and loss of control. In families in which the goal has been rigid control, the experience of emotion represents failure. Offenders from these families have not experienced emotions as tools for intimacy, trust, communication or problem solving. Many offenders experience the world as divided into two groups - victims and aggressors. They conceptualise emotional statements as attacks and conceptualise the process of communication as a battle to be won. Disclosing emotion becomes a traitorous act that provides top secret information to the enemy , and the experience of emotion becomes aversive because of its association with combat and failure.

An additional reason for offenders fear of emotion is that occasional protestation, they understand very clearly the association between negative emotion and sexual aggression. Often when angry, lonely or worried, they have fantasised about sexual aggression to gain momentary escape from these emotions. This connection may seem automatic to them. Offenders may fear that allowing themselves to actually experience emotions could result in a loss of self control.

In therapy individuals become aware that the particular demands of a situation precedes and triggers an adaptive or maladaptive strategy. How a situation is evaluated depends, in part, at least, on the relevant underlying beliefs. Those beliefs are embedded in more or less stable structures, labeled "schemas" that select and synthesise incoming data. The psychological sequence progresses then from evaluation to affective and motivational arousal, and finally to selection and implementation of a relevant strategy (Beck, Freeman et als 1990). When an individuals belief system is based on cognitive distortions that attribute responsibility for his behaviour to external to influences outside his control which is the case for child sex offenders (Larsen 1991), and the individual lacks empathy for others, then the focus of therapy is for the individual to reassess these belief systems and make the necessary changes in how these belief systems operate. The individuals functioning in the therapy programme will give him opportunity to "test" these belief systems in group therapy facilitated by his therapist and in the therapeutic mileu of the custodial enviroment.

The focus of therapy is that each individual is ultimately responsible for choosing his own reality and the identity that is embedded in it. According to Safran and Greenberg (1989), emotions are allies in a change process rather than a negative or undesirable aspect of a clients performance to be bypassed or extinguished. They suggest that for the purposes of intervention, distinctions initially need to be made between four broad categories of emotional expression;

- A) Biologically adaptive primary affective responses. These experiences provide information to the organism about its responses to situations. Emotions such as anger to violation, sadness to loss and fear in response to danger provide adaptive action tendencies to help organise appropriate behaviour. These emotions are often not initially in awareness and are to be accessed and intensified in therapy and used as aids in problem solving.
- B) Secondary reactive emotional responses. These responses are often problematic and are not the organism's direct response to the environment. Rather they are secondary to some underlying more primary generating process or are reactions to the thwarting of primary responses. Defensive or reactive responses such as crying in frustration when angry or expressing anger when afraid are secondary emotional responses to underlying emotional processes. In addition emotions such as fear in response to anticipated danger or hopelessness in response to negative expectations are secondary emotional responses to underlying cognitive processes. Secondary reactive responses of these types are not to be focused on or intensified in therapy; rather they are to be bypassed or explored in order to access underlying processes. Secondary emotions are generally readily available in awareness and often are part of the presenting problem.
- C) Instrumental emotional responses. These responses are emotional behaviour patterns that people have learned to influence others. These emotions are expressed in order to achieve some intended effect, such as crying to evoke sympathy or expressing anger in order to dominate. Instrumental expressions of this type are not information about responses to situations but attempts to influence. In therapy, these expressions are best bypassed, confronted or interpreted, not explored or differentiated to access adaptive information.

- D) Learned maladaptive primary responses include fear in reaction to harmless stimuli or anger in response to caring. Although the emotional response system generally plays an adaptive role in human functioning, maladaptive responses can be learned as a function of trauma or strongly negative emotional contingencies in childhood. These emotions need to be accessed in therapy, but they are to be modified rather than used for orientation.

The task for the men in therapy is to gain some insight into their cognitive, affective and behavioural functioning and to make the necessary treatment gains in each module which will strengthen their capacity to recognise their Relapse process and to employ the necessary strategies to maintain a non offending lifestyle.

The following research was undertaken to assist the programme providers development of the programme modules through providing data on individuals emotional experience and sexual cognitions and behaviour. There has been some speculation that the men in treatment may develop a negative emotional state which prevents them from making therapeutic gains. It was also hoped that this study would provide more information about the link between negative mood and the use of compensatory sexual cognitions (e.g. fantasy) and behaviour. It has been suggested in the clinical formulations which use the Relapse model that negative emotional states are often a precursor of offending.

RATIONALE

1) To investigate whether there is a relationship between mood states and sexual preoccupation for any of this population of men. What if any relationship is there between self report of sexual behaviour and negative emotions.

2) Clinically we are aware that men in treatment experience extreme negative affect and rapid shifts in mood during the first modules of the programme. This research project is an experimental approach to investigate individuals emotional experience during the cognitive restructuring, victim empathy and arousal reconditioning modules. Specifically their response to disclosing their offending cycle to their group, acknowledging the harm to their victims, and becoming aware of their deviant arousal and making the connection with their thoughts and fantasies.

3) In order to effectively implement the Relapse Prevention strategies it is important that offenders: a) learn to identify their emotional experiences and implement effective coping strategies, b) monitor their sexual thinking and behaviour. It has been the clinical impression that many of the men are limited in their capacity to identify and label their emotional and sexual experiences. This experimental investigation follows the self report of men's emotional experience on a daily basis, for 100 days, before they do the coping skills module.

HYPOTHESIS

That negative emotional state and sexual preoccupation will covary.

PART TWO

METHOD

Subjects:

The subjects were men who volunteered to undertake the Kia Marama Specialist Treatment Programme. These men were the participants of two therapy groups, commencing treatment during 1993. The space between the start times of these groups was approximately six weeks. Two men asked to withdraw from the study within the first two weeks, three others did not comply with the requirements of the self report task, their issues will be discussed in a later section.

The 14 men who are the subjects of this research ranged in age from 19 years to 57 years, all were Caucasian. All of the men were incarcerated for offences against children. The major offence for which they were imprisoned are as follows;

- Sexual Violation (10),
- Indecent Assault (2),
- Unlawful Sexual Intercourse (1), and
- Abduction (1).

(see Appendix 2).

PROCEDURE:

Each man was approached by the researcher and asked if he would be willing to involve himself in this study, which involved self report over the first 100 days of therapy i.e. the cognitive distortions, sexual reconditioning and victim impact/empathy modules. An outline of the research proposal was explained, (see Appendix 3), and what would be expected of the participants. The benefits to the individual, as well as the benefit of such an investigation for the future development

of the programme, was discussed, e.g. the use of a daily diary is advocated in many programmes which treat addictive type behaviours.

Confidentiality and informed consent

Each man was given a copy of the consent form, (see Appendix 4) and asked to think about whether he wished to commit himself to returning 100 days of self report as well as filling out the Beck Depression Inventory, BDI, State-Trait Anger Inventory STAXI and the State-Trait Anxiety Inventory, STAI forms after the Cognitive Distortions Module and again at the end of the 100 days. Each man was assured of confidentiality, and that the information from this research would not be used to effect his release date in any way. Also each man was assured that he could withdraw without prejudice at any time.

The ethical issues and research design, were approved by the Kia Marama Therapy Staff and the Psychology Department of the University of Canterbury.

Self report

The men who chose to participate were given a block of 100 self report pages which were individually coded with a confidential code number, known to them and the researcher. The men were asked to mark on each of the 6 scales of emotion weighted positively and negatively, how they had been feeling over the past 24 hours, and to record their sexual cognitions and behaviour in the boxes on the same page. (See Appendix 5). An explanation of the terms used; sexual urge, sexual fantasy, masturbation, orgasm was attached to the self report pages. The men were asked to fill out the form at around the same time each day and then to post it in a secure, anonymous, "drop box" positioned in the therapy unit. The men were

spoken to individually within the first week of the data collection and asked if they had any difficulties with the procedure. They were encouraged to speak to the researcher or her supervisor if they had any questions in the future about their involvement in the research project.

Emotion Self Report

The six emotion scales were an adaptation of the Differential Emotion Scale (Izard, Doughty, Bloxom & Kotch, 1974). This self report scale (D.E.S) measures the presence of 12 basic emotions using a five point Likert scale. There are 36 items, (three per emotion), with possible scores from each emotion ranging from 3-15. This scale has a number of different forms, and was designed for people with limited education. The psychometric properties are satisfactory (Boyle, 1984).

The requirements of this study was a series of positive-negative emotions scales which investigated those emotional experiences that the men have reported most often clinically in the programme, i.e sadness, anger externalised/internalised, loneliness, worry, and shame/guilt; and which are thought to be associated with offence precursors. The use of these scale is an experimental attempt to assess the levels of positive versus negative affect. The scales were not anchored with number values, they measured 100 millimetres in length, and were scored with the use of a scoring sheet, (See Appendix 6) to the nearest 5 millimetres. Zero being weighted at the positive end and 100, at the negative end. e.g. Happy, 0, Sad 100. The scales were positioned on the self report page in such a way that the positive - negative anchors did not all run from left to right.

Self report sexual cognition and behavior.

The categories used were developed from the work of Jones and Barlow (1990), using their differentiation of sexual urges (externally generated) and sexual fantasies (internally generated). The intention of the researcher was to break sexual cognitions and behaviour into discreet parts by way of an experimental investigation. These categories could then be summed to give a total score of sexual experience for the individual. It should be noted that the researcher did not ask the men to differentiate the nature of their cognitions i.e. whether deviant or not.

The daily self report sheets were collected by the researcher, scored and the answers recorded. The data was then entered into a statistical package, using 12 variables (6 emotion scales + 4 sex reports + 2 totals) over 1400 cases (14 subjects x 100 days). The results for each individual were correlated and graphs were generated using a moving average.

Assessment Questionnaires

The psychological questionnaires used to assess emotion in the programme during the assessment phase were repeated twice for the purposes of this study. The second measure was made at the end of the sexual reconditioning module, before victim impact/empathy and again at the end of the 100 days. The researcher decided to use these questionnaires as an independent measure of the emotional functioning of the group members.

The Anger Expression Scale - STAXI, (Spielberger, Crasner & Solomon, 1988), was designed to assess the individual difference in the intensity of anger as an emotional state and the proneness to anger as a personality trait; it also measures the extent

to which people express anger (anger out) or suppress (anger in) their angry feelings in terms of reactions or behaviours. In designing the anger expression scale, Spielberger and colleagues assumed that anger expression could most meaningfully be defined in terms of a single bipolar dimension, for which the behaviours ranged from strong inhibition or suppression of angry feelings to extreme expression of anger toward other persons in the environment. A subscale of the test is anger control, or a resistance to becoming angry. According to Glass (1977), Type A persons endeavour to gain and maintain control over their environment and continue to try to dominate even after it becomes clear that the situation is unmanageable. When they are frustrated in gaining or maintaining control they experience anger. Spielberger et al. reported that individuals who used a great deal of energy in controlling the expression of anger were also more likely to use the over-rationality, repression and denial as defences for controlling their emotions.

The Beck Depression Inventory (BDI) short form, , differentiates between Normal 0-9, Mild depression 10-20, Moderate (10-17, dysphoria), 21-30 moderately depressed and 30+ severe depression. The Inventory has 13 items. The psychometric properties of this test are satisfactory (Beck, Steer & Garbin, 1988).

The State-Trait Anxiety inventory (STAI, Spielberger et al., 1970) is one of the most widely used self report measures of subjective anxiety, comprises a 20 item scale. Half the items assess state anxiety, how they feel at the time they are filling in the questionnaire and trait anxiety, how they generally feel. Both the state and trait scales are used extensively in clinical practice where either a screening of anxiety level or an ongoing monitor of anxiousness is needed (Knight, Hendrika, Waall-Manning and Spears, 1983).

RESULTS

A graph of the data for the 6 subscales, the total of these scales and the total of the sexual cognitions and behaviour was produced for each of the subjects. On the graphs the time periods of the modules were marked, i.e., cognitive distortions, sexual reconditioning, and victim impact/empathy. Also marked on the graphs are the days when each subject was in the "hotseat"; the focus of the group disclosing his issues. Correlation matrices for the scales and total scores were produced for each subject. The graphs and correlations will be presented individually with comments.

Anova results were produced for the BDI, STAI, STAXI measures for the total number of subjects and also a between group comparison.

A one factor repeated measure anova was produced for the cumulative means of the 14 subjects. As can be seen from table 1., there were no significant changes in the means of BDI $F(2,26)=.99$, STAI (state) $F(2,26)=1.12$, STAI (trait) $F(2,26) =.009$, STAXI (state) $F(2,26)=2.16$, STAXI (trait) $F(2,26)=1.2$, STAXI(Expression) $F(2,26)=0.1$, STAXI (Suppression) $F(2,26)=0.61$, STAXI (Control) $F(2,26)=2.8$, although the anova scores indicated a strong trend for the last measure.

TABLE 1	1	2	3
BDI	13.4	14.2	10.4
STAI (state)	39.5	44.6	37.6
STAI (trait)	43.6	43.5	44.1
STAXI (state)	12.3	14.7	12.7
STAXI (trait)	18.5	17.1	17.2
STAXI (expression)	15.5	15.6	15.2
STAXI (suppression)	20.2	18.6	19.1
STAXI (control)	22.0	24.7	23.4

A repeated measure anova was produced to compare these scores between the two groups. As can be seen from table 2, there was a significant difference between the groups on BDI $E(1,24)=4.8$, $p<.05$, STAI (trait) $E(1,24)=6.5$, $p<.05$ and STAXI (trait) $E(1,24)=5.2$, $p<0.5$; the other measures were not significant, STAI (state) $E(1,24)=3.49$, STAXI(state) $E(1,24)=1.6$, STAXI (expression) $E(1,24)=0.003$, STAXI (suppression) $E(1,24)=2.5$, and STAXI (control) $E(1,24)=1.13$.

AVERAGE TOTALS ACROSS MEASURES

TABLE 2	GROUP 1	GROUP 2
BDI	8.88	17.7
STAI (state)	37.0	45.4
STAI (trait)	39.7	49.2
STAXI (state)	12.4	14.4
STAXI (trait)	16.1	19.1
STAXI (expression)	15.4	15.5
STAXI (suppression)	18.3	20.6
STAXI (control)	24.1	22.4

RESULTS OF CORRELATION MATRICES AND GRAPHS

The results are presented as follows; Each subject Total 1 Graph, the sum of all the mood scores over the 100 days of data collection into modules.

Module 1, Cognitive Distortions; Module 2, sexual reconditioning; and Module 3, Victim Impact/Empathy. Also three points are marked Point A, when the subject first disclosed his offending cycle to the group, Point B, when he reviewed his offending cycle with his group and point C, when he role played his understanding of his victims issues for the group. The sub scales for each subject are in Appendix 7.

SUBJECT ONE

Relationship between scales: There is a high degree of correlation amongst the first three subscales, the 5th scale does not correlate well with anything. The total mood score correlates well with the other scales apart from scale 5 (proud/ashamed).

The graphs reveal peaks of negative affect prior to point A, immediately after point B and C. There is another definite peak in the middle module two. The range of total affect was between 0-300. This indicated that mood gradually improved the second time in the "hotseat" it then increased to the end of the module.

The total sex score increased after being in the "hotseat", during reconditioning and at point C.

PEARSON CORRELATION MATRIX

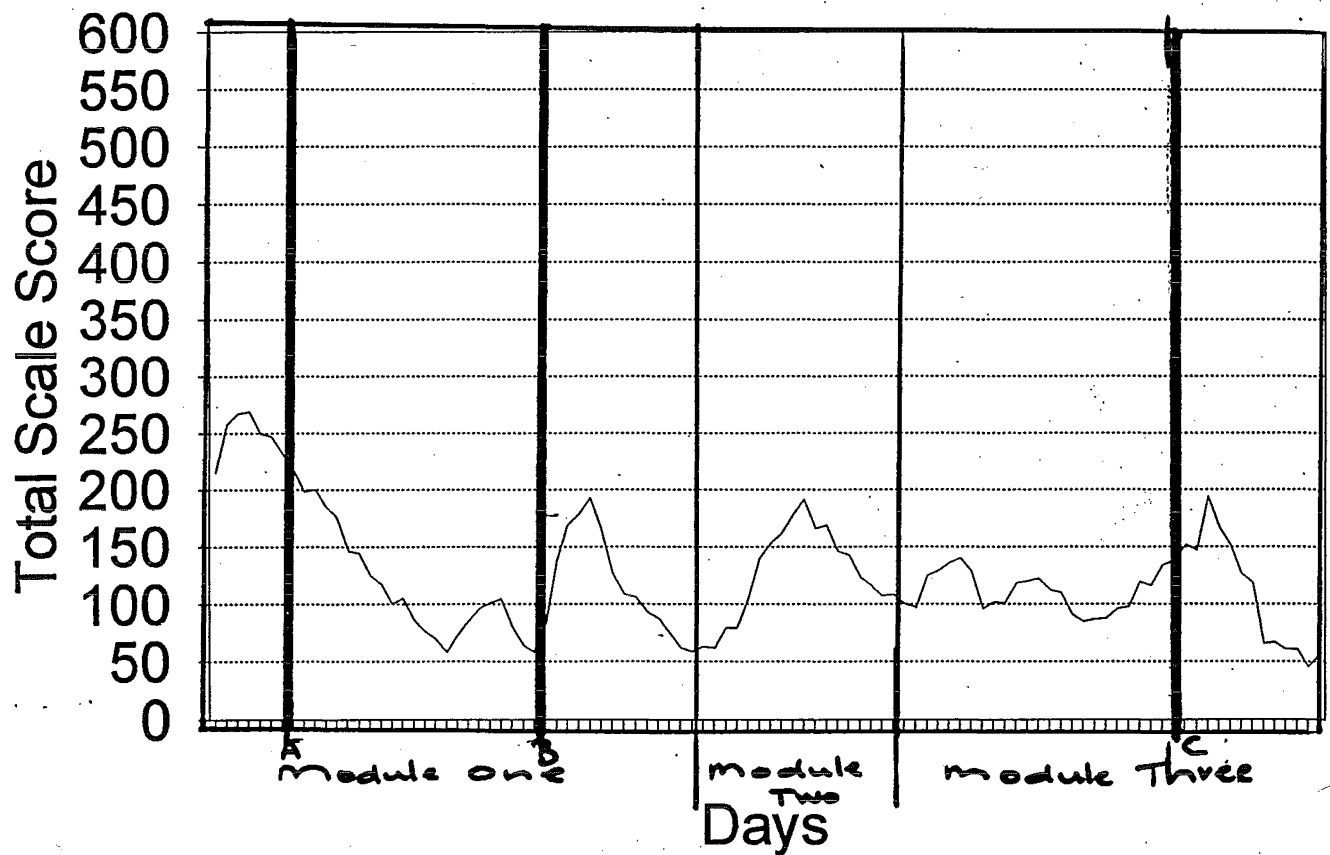
Note: Significant values are shown in **bold** type.

SUBJECT No 1

	HAPPY/SAD	SOCIABLE/ LONELY	CALM/ ANGRY	GOOD TEMP/ BAD TEMP	PROUD/ ASHAMED	PEACEFUL / WORRIED	TOTAL 1 EMOTION SCORES	TOTAL 2 - SUM OF SEX SCORES
HAPPY/SAD	1.000							
SOCIABLE/LONELY	0.829	1.000						
CALM/ANGRY	0.939	0.909	1.000					
GOOD TEMP/ BAD TEMP	0.835	0.826	0.871	1.000				
PROUD/ASHAMED	0.148	-0.194	0.071	0.084	1.000			
PEACEFUL/WORRIED	0.800	0.610	0.766	0.552	0.335	1.000		
TOTAL 1 Emotion Scores	0.971	0.878	0.973	0.875	0.185	0.850	1.000	
TOTAL 2 - SUM OF SEX SCORES	0.319	0.138	0.305	0.283	0.305	0.301	0.318	1.000

Subject 1.

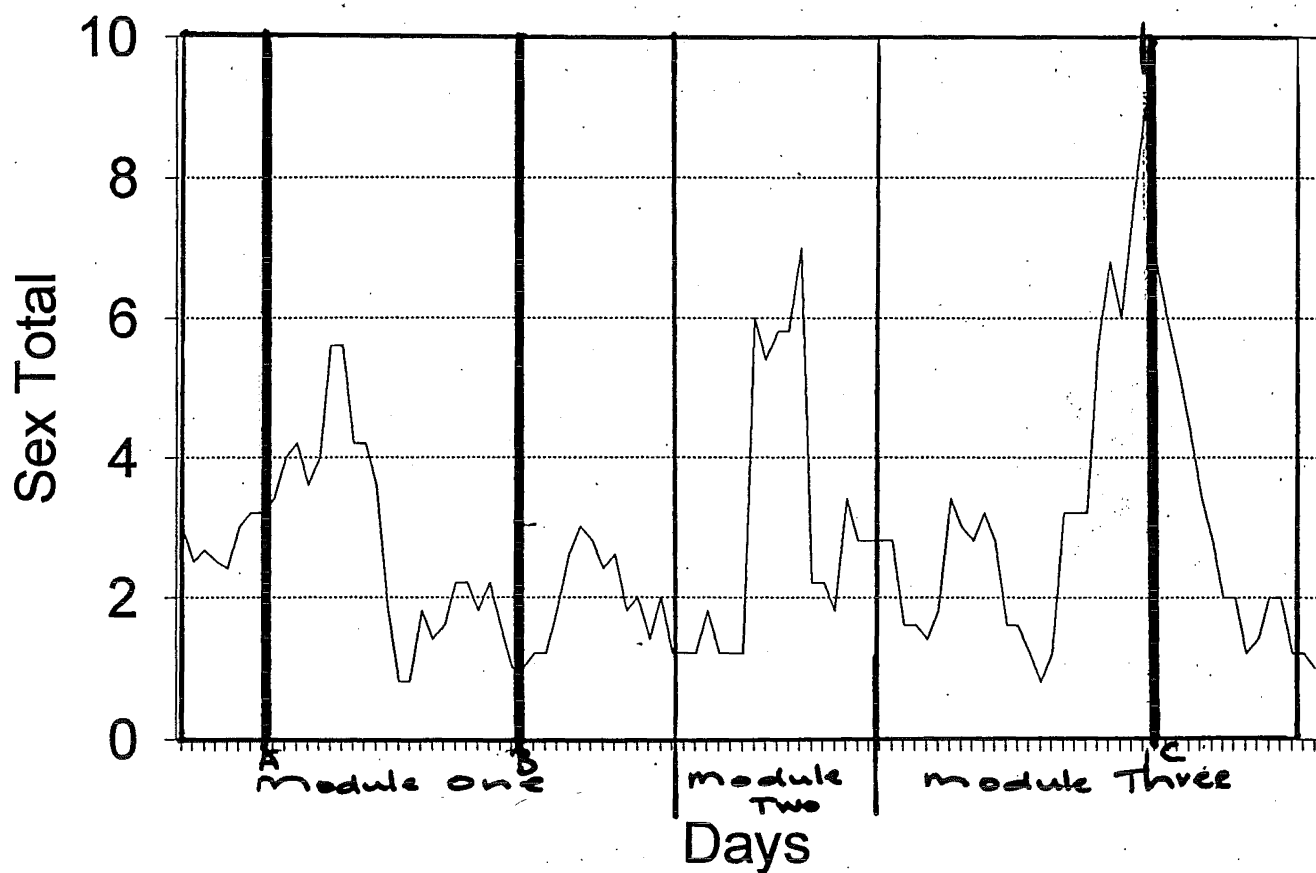
Subject 1 Total



- A - Cognitive Distortions
- B - Cognitive Distortions.
- C - Victim Impact / Empathy.

Subject 1.

Subject 1 Total 2



- A - Cognitive Distortions
- B - Cognitive Distortions.
- C - Victim Impact / Empathy.

SUBJECT TWO

The relationships between each scale and the total are all consistently high. There is no significant correlation between total two and the other scores, those reported are all negative.

The graphs 1 - 6 and Total 1 indicate a decrease in negative report over the first module, report consistent positive affect during module two and two peaks on module three, the highest several days after point C, victim autobiography. At point A there is a dip in negative affect .

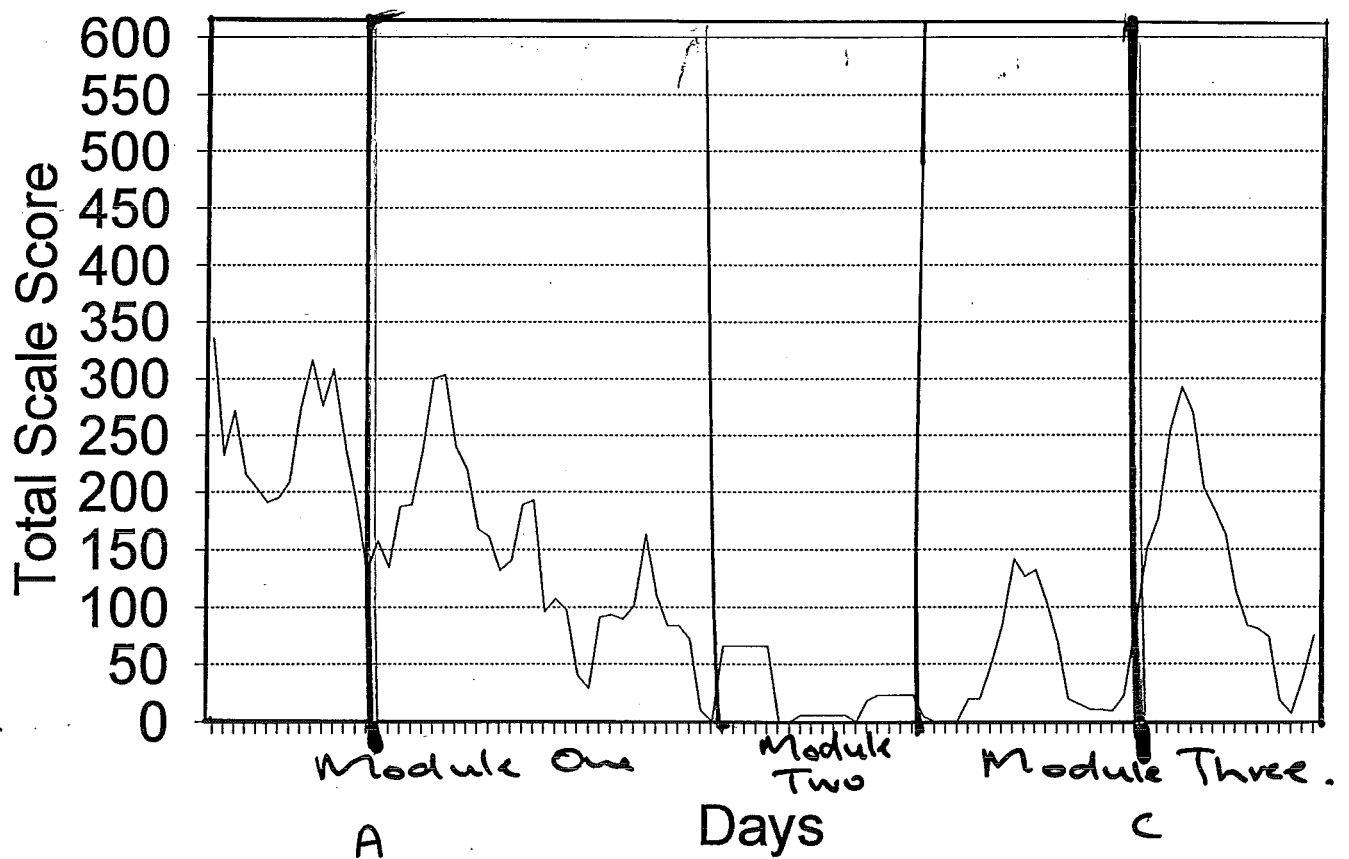
The graph of total 2 shows an increase over modules which dropped away sharply at point C.

SUBJECT No 2

	HAPPY/SAD	SOCIABLE/ LONELY	CALM/ ANGRY	GOOD TEMP/ BAD TEMP	PROUD/ ASHAMED	PEACEFUL / WORRIED	TOTAL 1 EMOTION SCORES	TOTAL 2 - SUM OF SEX SCORES
HAPPY/SAD	1.000							
SOCIABLE/LONELY	0.955	1.000						
CALM/ANGRY	0.909	0.855	1.000					
GOOD TEMP/ BAD TEMP	0.902	0.875	0.942	1.000				
PROUD/ASHAMED	0.896	0.939	0.869	0.820	1.000			
PEACEFUL/WORRIED	0.817	0.895	0.732	0.744	0.882	1.000		
TOTAL 1 Emotion Scores	0.965	0.976	0.933	0.929	0.957	0.902	1.000	
TOTAL 2 - SUM OF SEX SCORES	-0.239	-0.223	-0.399	-0.295	-0.425	-0.236	-0.320	1.000

Subject 2.

Subject 2 Total 1

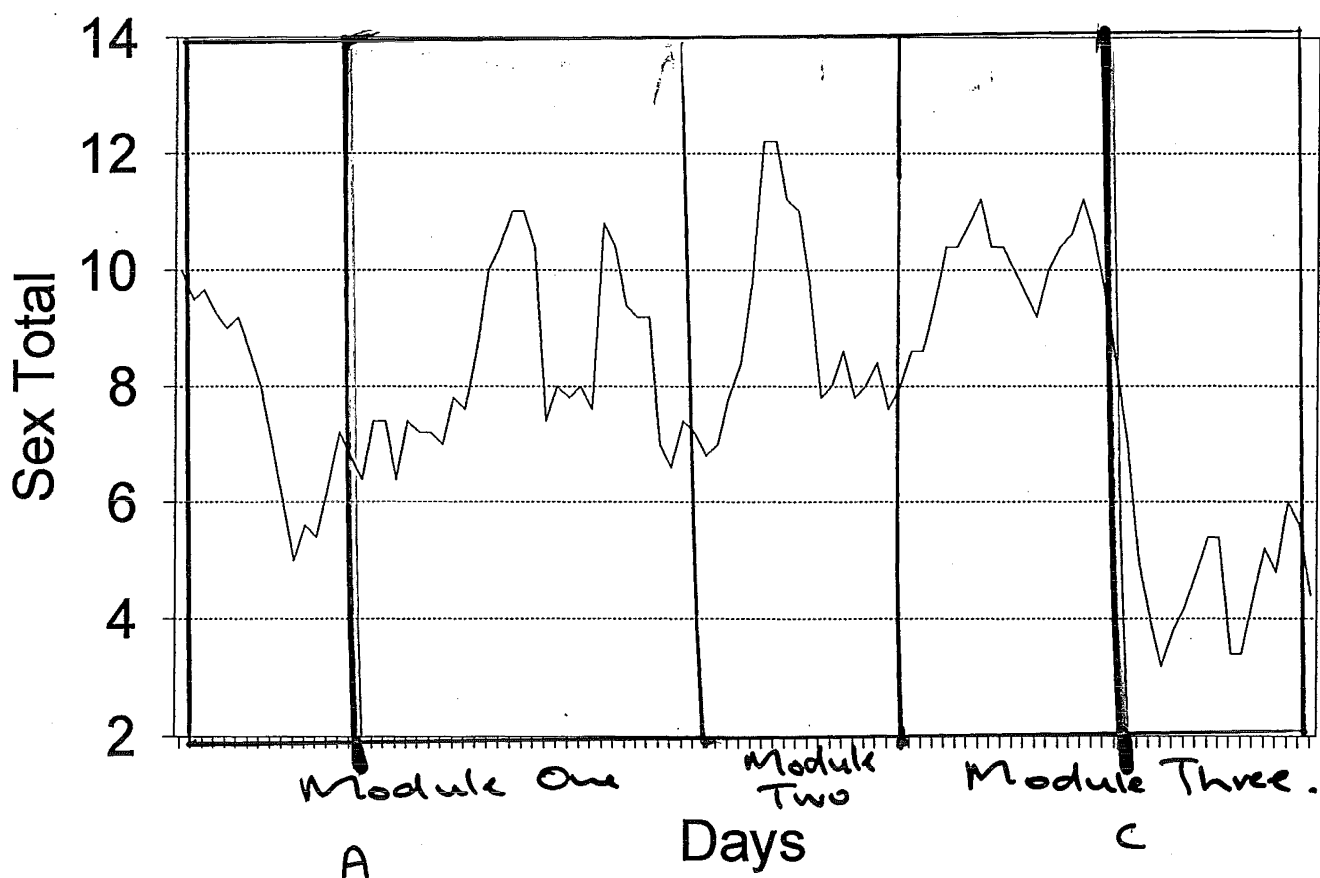


"Hotseat"

- A Cognitive Distortions Offense Cycle 1
- B No Recording.
- C Victim Impact Empath.

Subject 2.

Subject 2 Total 2



Hotseat

- A Cognitive Distortions Offense Cycle 1
- B No Recording.
- C Victim Impact Empath.

SUBJECT THREE

The relationships between all the scales and the total were high apart from, calm/angry with sociable/lonely and proud/ashamed. There are no significant correlations with the total 2, again those reported are all negative.

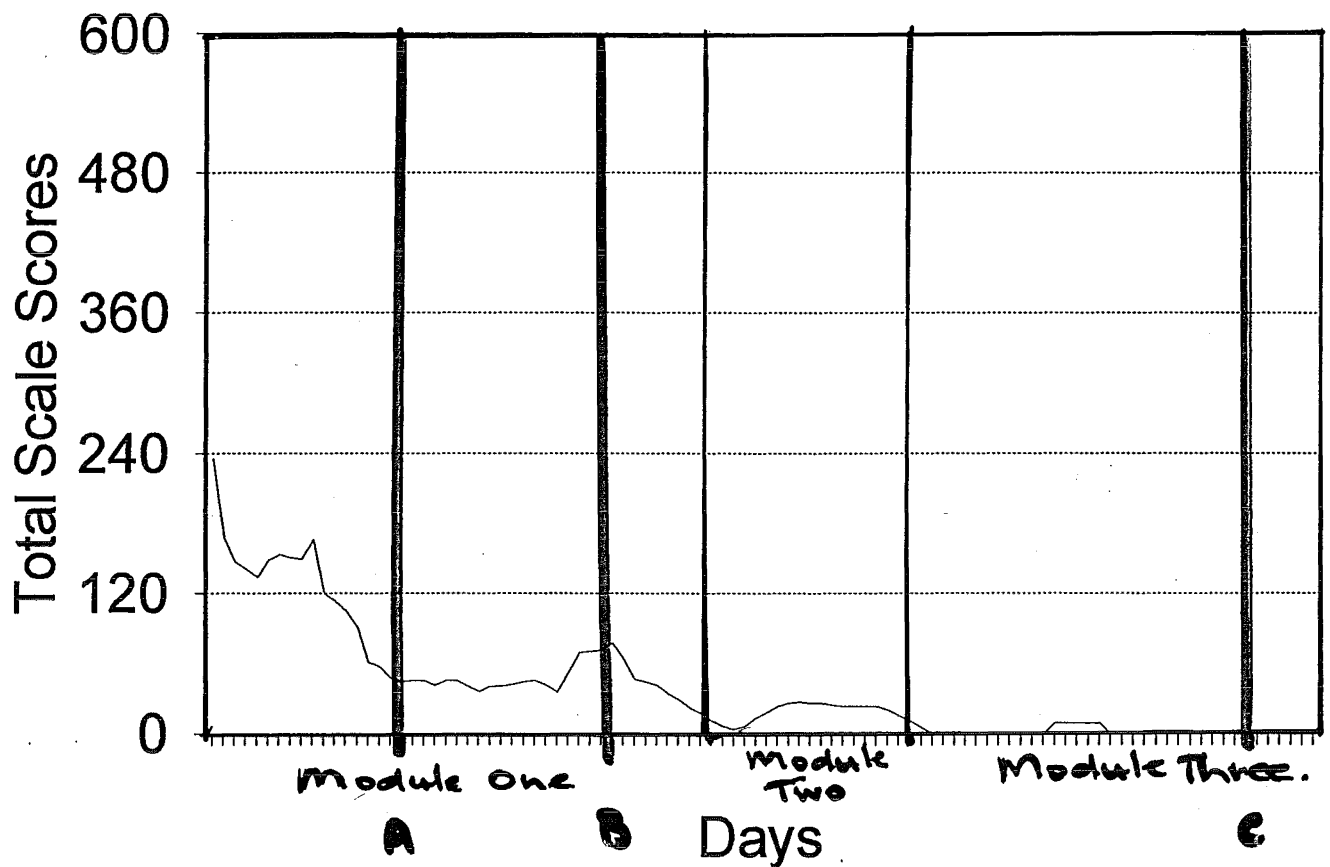
The graphs indicate a decrease in negative affect over the modules, with an increase at point B. During module three only positive affect was reported. The total sex graph shows increase in sexual activity after module two and throughout module three.

SUBJECT No 3

	HAPPY/SAD	SOCIABLE/ LONLEY	CALM/ ANGRY	GOOD TEMP/ BAD TEMP	PROUD/ ASHAMED	PEACEFUL/ WORRIED	TOTAL 1	TOTAL SEX
HAPPY/SAD	1.000							
SOCIABLE/LONLEY	0.759	1.000						
CALM/ANGRY	0.833	0.572	1.000					
GOOD TEMP/ BAD TEMP	0.928	0.763	0.883	1.000				
PROUD/ASHAMED	0.903	0.770	0.573	0.824	1.000			
PEACEFUL/WORRIED	0.932	0.793	0.800	0.978	0.864	1.000		
TOTAL 1	0.968	0.874	0.827	0.963	0.902	0.965	1.000	
TOTAL SEX	-0.314	-0.328	-0.336	-0.433	-0.288	-0.446	-0.380	1.000

Subject 3

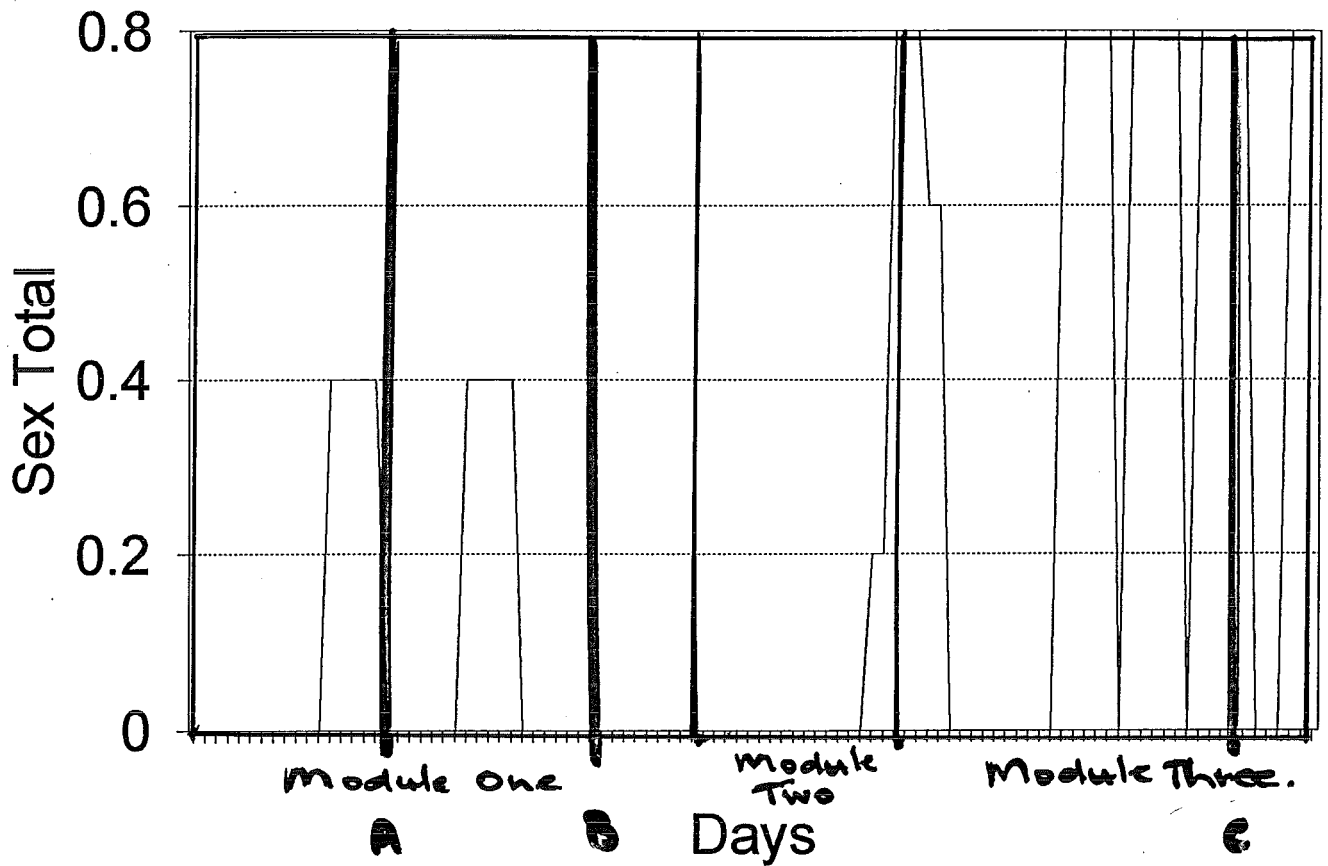
Sub 3 Total 1



A - Cognitive Distortions offence Cycle 1
B - Cognitive Distortions offence Cycle 2
C - Victim Impact/Empathy ~~1~~

Subject 3

Subject 3 Total 2



- A - Cognitive Distortions offence Cycle 1
- B - Cognitive Distortions offence Cycle 2
- C - Victim Impact/Empathy ~~1~~

SUBJECT FOUR

The relationship between subscales and total 1 is consistently high. There was no demonstrable relationship between total 2 and the other totals.

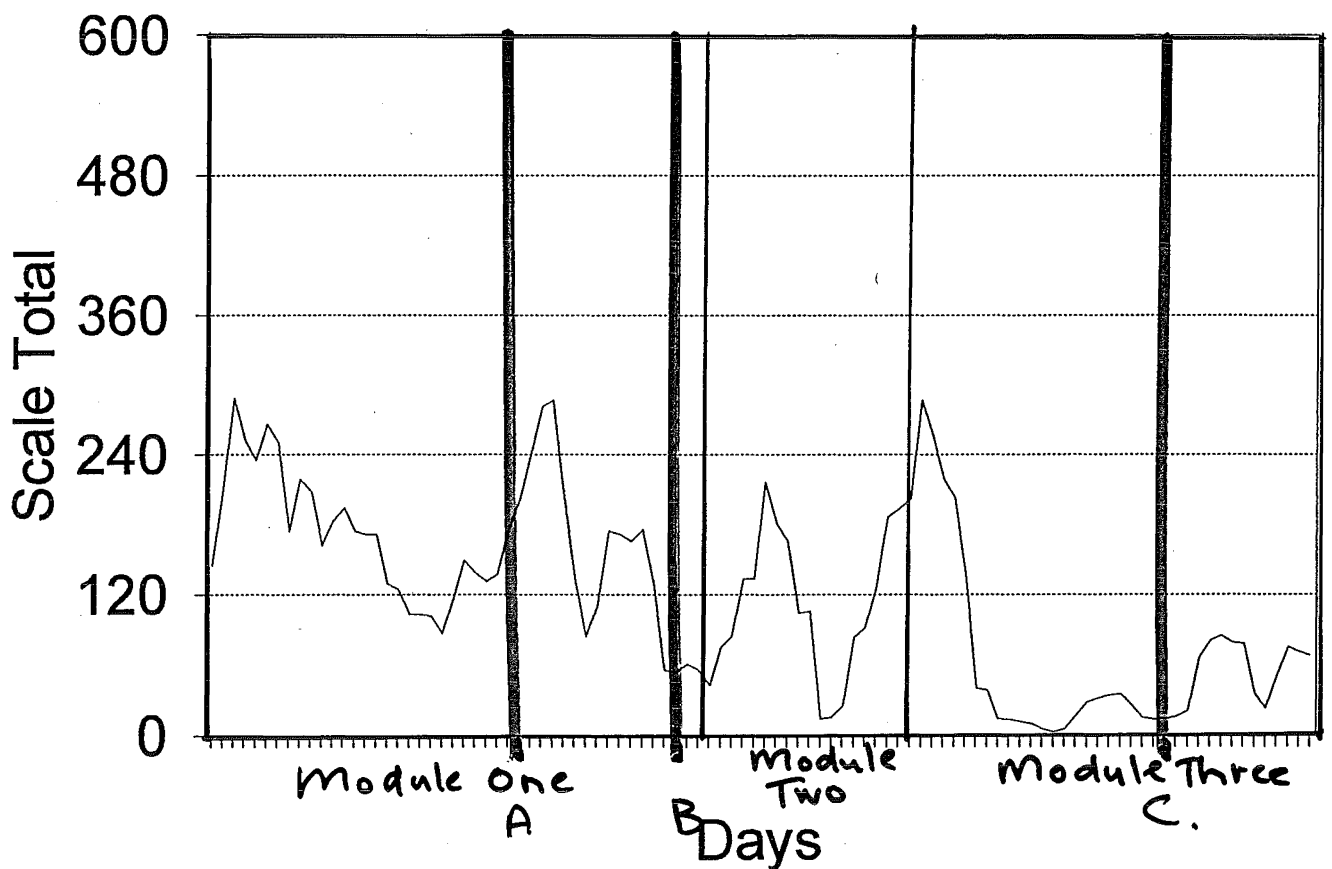
The graphs show a peak of negative affect after point A, but not B, During module three there were consistent levels of positive affect. The graph of total two shows higher levels at beginning of module one which drops away between point A and B, an increase to point C, and then reduction to low levels.

SUBJECT No 4

	HAPPY/SAD	SOCIABLE/ LONELY	CALM/ ANGRY	GOOD TEMP/ BAD TEMP	PROUD/ ASHAMED	PEACEFUL / WORRIED	TOTAL 1 EMOTION SCORES	TOTAL 2 - SUM OF SEX SCORES
HAPPY/SAD	1.000	S						
SOCIABLE/LONELY	0.900	1.000						
CALM/ANGRY	0.917	0.885	1.000					
GOOD TEMP/ BAD TEMP	0.828	0.816	0.942	1.000				
PROUD/ASHAMED	0.771	0.715	0.840	0.917	1.000			
PEACEFUL/WORRIED	0.867	0.906	0.882	0.875	0.846	1.000		
TOTAL 1 EMOTION SCORES	0.933	0.921	0.969	0.956	0.906	0.955	1.000	
TOTAL 2 - SUM OF SEX SCORES	0.302	0.325	0.164	-0.011	-0.100	0.226	0.154	1.000

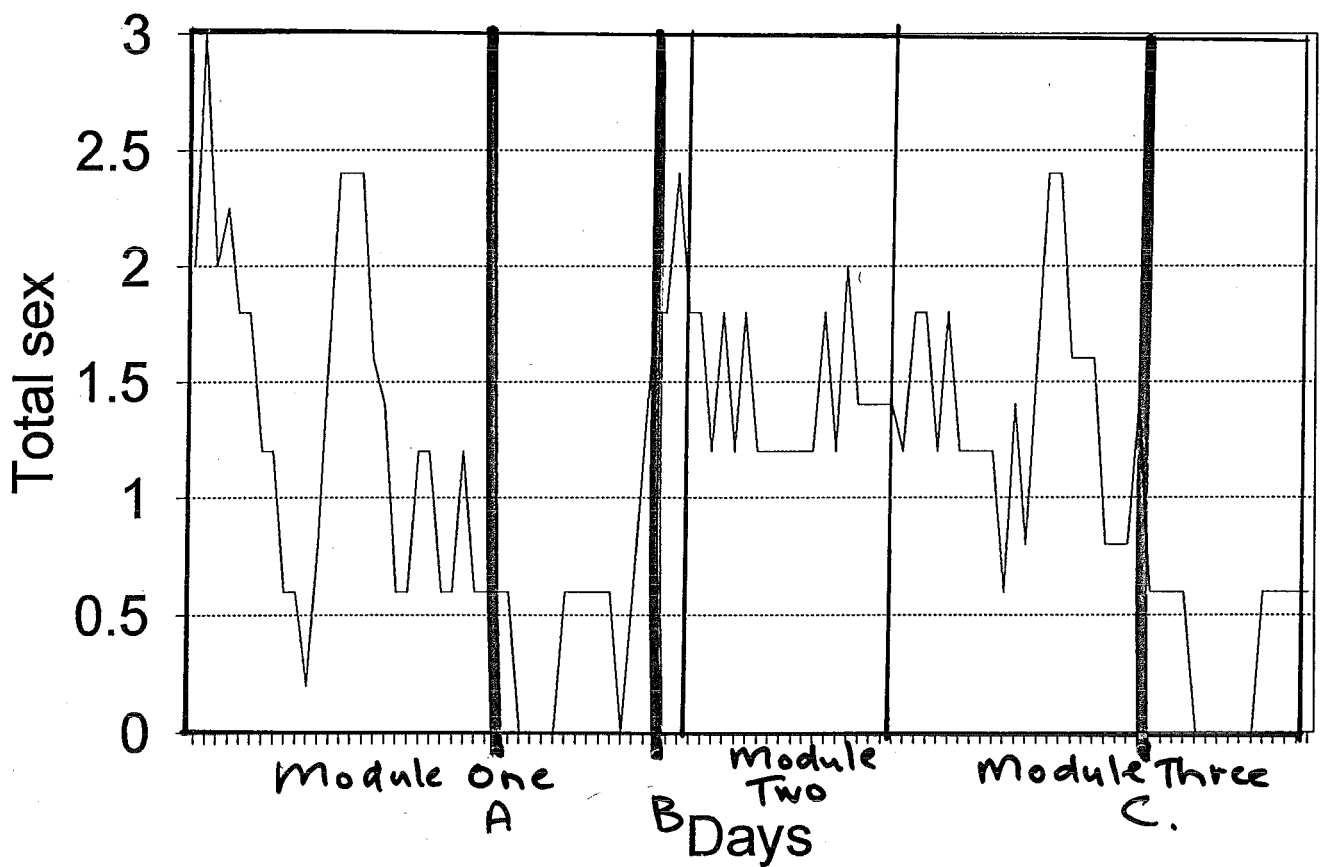
Subject 4

Sub 4 Tot 1



Subject 4

Sub 4 Total 2



"Hotseat"

- A - Cognitive Distortions - Offence Cycle 1
- B - Cognitive Distortions - Offence Cycle 2
- C - Victim Impact / Empathy

SUBJECT FIVE

There were no significant relationships between the scales. The only significant correlations were between the total mood score and scale 3 (calm/angry), scale four (good tempered/bad tempered) and scale five (peaceful worried). There was no significant relationship with total two.

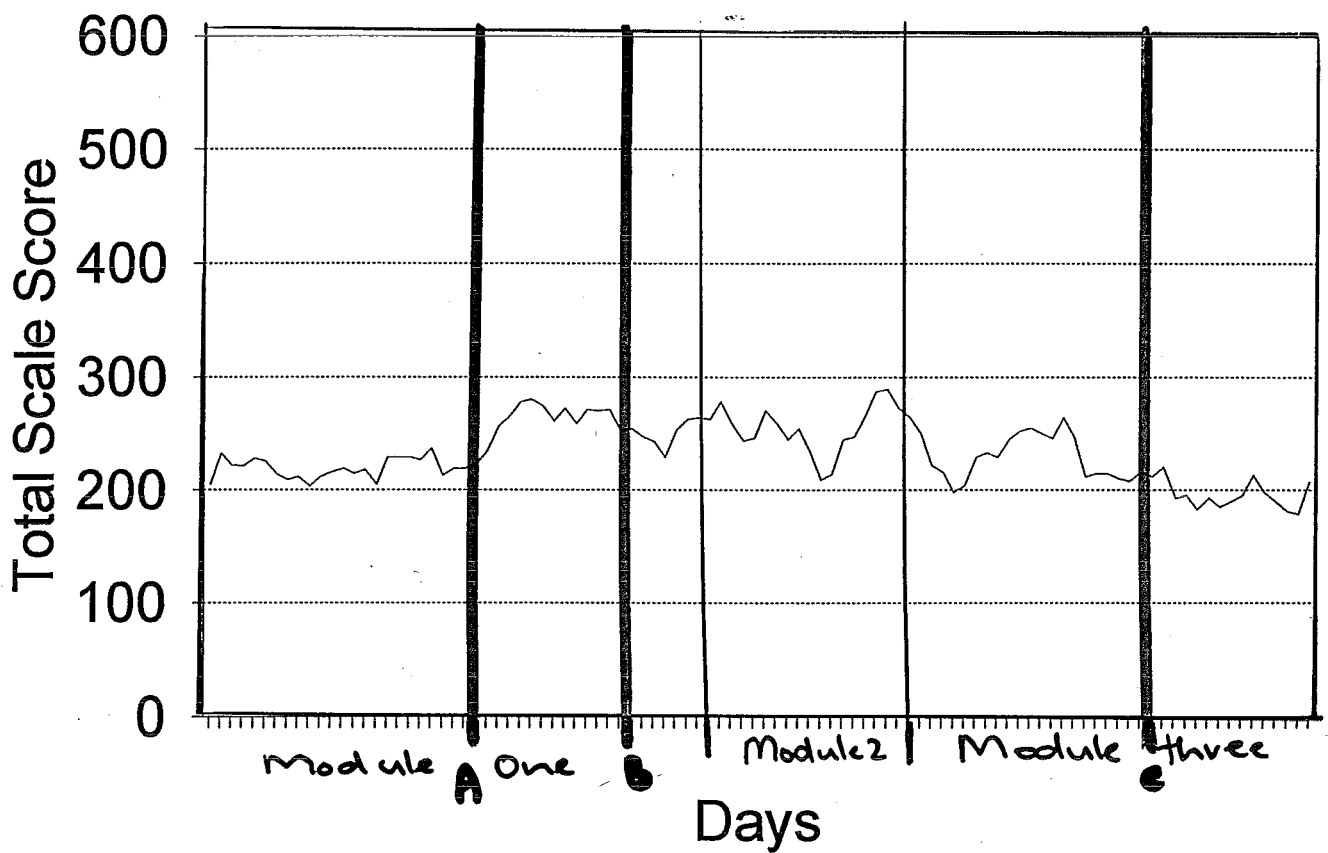
The graphs of total one shows the total swing of affect in a range of 100 points. The graph of total two shows a return to zero at point A, a dip and point B, and a return to zero for several days at point C , with a return to previous levels

SUBJECT No 5

	HAPPY/SAD	SOCIABLE/ LONELY	CALM/ ANGRY	GOOD TEMP/ BAD TEMP	PROUD/ ASHAMED	PEACEFUL / WORRIED	TOTAL 1 EMOTION SCORES	TOTAL 2 - SUM OF SEX SCORES
HAPPY/SAD	1.000							
SOCIABLE/LONELY	0.082	1.000						
CALM/ANGRY	0.013	-0.066	1.000					
GOOD TEMP/ BAD TEMP	-0.207	0.249	0.572	1.000				
PROUD/ASHAMED	0.336	-0.278	-0.300	-0.448	1.000			
PEACEFUL/WORRIED	-0.254	0.084	0.617	0.645	-0.518	1.000		
TOTAL 1 EMOTION SCORES	0.141	0.220	0.839	0.784	-0.267	0.781	1.000	
TOTAL 2 - SUM OF SEX SCORES	-0.012	-0.311	0.474	0.064	0.181	0.221	0.313	1.000

Subject 5

Sub 5 Total 1



"Hotseat"

- A - Cognitive Distortions offence Cycle 1
- B - Cognitive Distortions offence Cycle 2
- C - Victim Impact / Empathy

SUBJECT SIX

Fairly high level of correlation between the scales and the total with an absence of relationship between scale three and any of the others. None of the measures of total two correlated with the others and they were all negative.

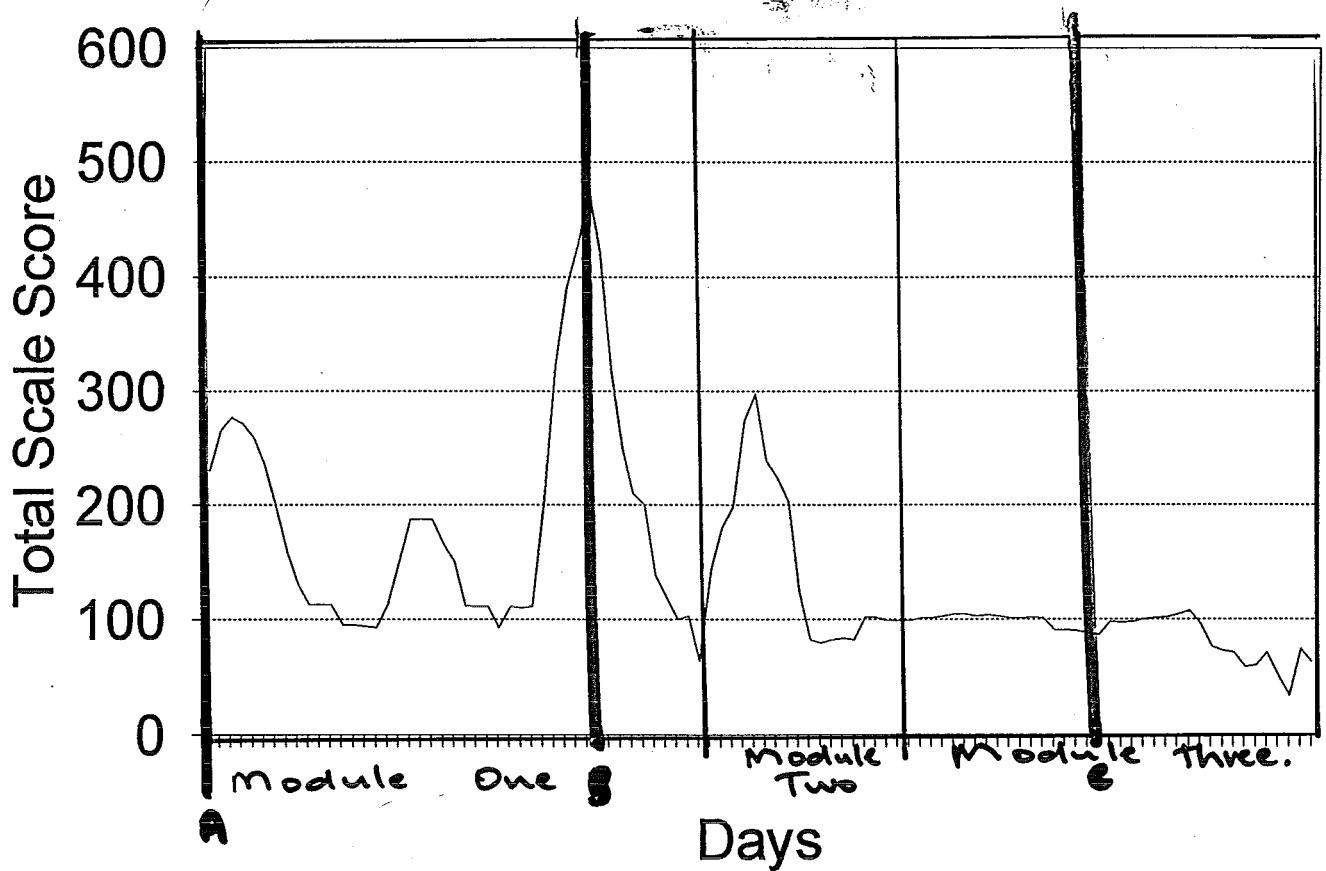
The graphs show a peak of negative affect after point A and at point B, another followed during module two and then flattened out into positive affect during module three.

SUBJECT No 6

	HAPPY/SAD	SOCIABLE/ LONELY	CALM/ ANGRY	GOOD TEMP/ BAD TEMP	PROUD/ ASHAMED	PEACEFUL / WORRIED	TOTAL 1 EMOTION SCORES	TOTAL 2 - SUM OF SEX SCORES
HAPPY/SAD	1.000							
SOCIABLE/LONELY	0.835	1.000						
CALM/ANGRY	0.575	0.711	1.000					
GOOD TEMP/ BAD TEMP	0.863	0.865	0.693	1.000				
PROUD/ASHAMED	0.154	-0.039	0.246	0.156	1.000			
PEACEFUL/WORRIED	0.853	0.827	0.520	0.903	0.020	1.000		
TOTAL 1 EMOTION SCORES	0.924	0.893	0.780	0.946	0.304	0.876	1.000	
TOTAL 2 - SUM OF SEX SCORES	-0.385	-0.379	-0.490	-0.401	-0.264	-0.351	-0.475	1.000

Subject 6.

Subject 6 Total 1

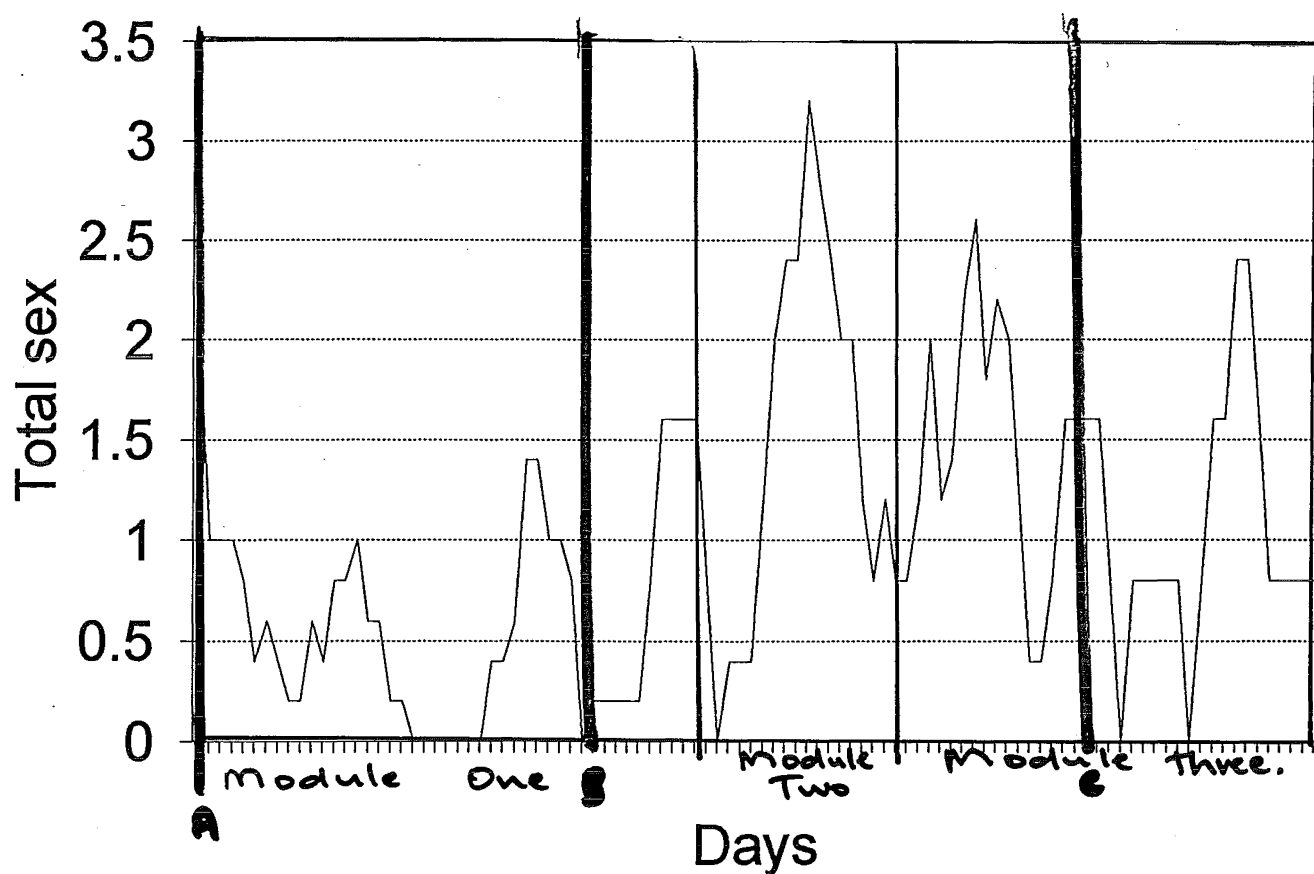


"Hotseat"

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact/Empathy.

Subject 6.

Sub 6 Total 2



'Hotseat'

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact/Empathy.

SUBJECT SEVEN

There are mostly high correlations between the subscales. Scale one (happy-sad) does not correlate as well with the others, apart from scale 5, proud/ashamed. All correlate well with the total. none of the relationships with total two are significant however several approach significance. All are negative relationships.

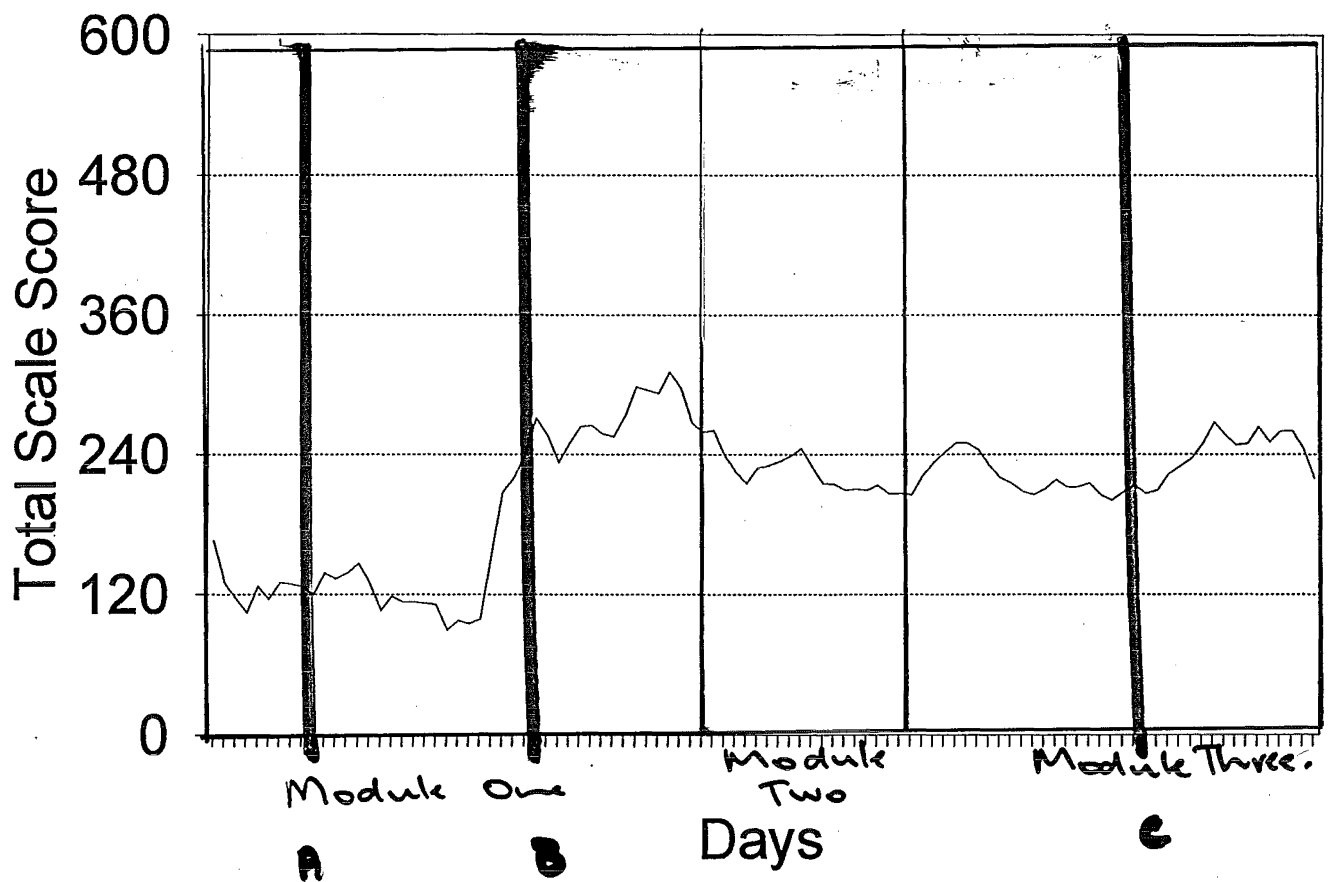
The graphs show an increase in total negative affect over the modules, with a definite increase at point B Total two decreased markedly from point B to midway through the second module, and dipped again at C.

SUBJECT No 7

	HAPPY/SAD	SOCIABLE/ LONELY	CALM/ ANGRY	GOOD TEMP/ BAD TEMP	PROUD/ ASHAMED	PEACEFUL / WORRIED	TOTAL 1 EMOTION SCORES	TOTAL 2 - SUM OF SEX SCORES
HAPPY/SAD	1.000							
SOCIABLE/LONELY	0.377	1.000						
CALM/ANGRY	0.567	0.867	1.000					
GOOD TEMP/ BAD TEMP	0.533	0.836	0.924	1.000				
PROUD/ASHAMED	0.873	0.591	0.732	0.691	1.000			
PEACEFUL/WORRIED	0.645	0.717	0.783	0.753	0.779	1.000		
TOTAL 1 EMOTION SCORES	0.819	0.794	0.902	0.870	0.923	0.897	1.000	
TOTAL 2 - SUM OF SEX SCORES	-0.291	-0.624	-0.577	-0.538	-0.295	-0.464	0.464	1.000

Subject 7.

Subject 7 Total 1

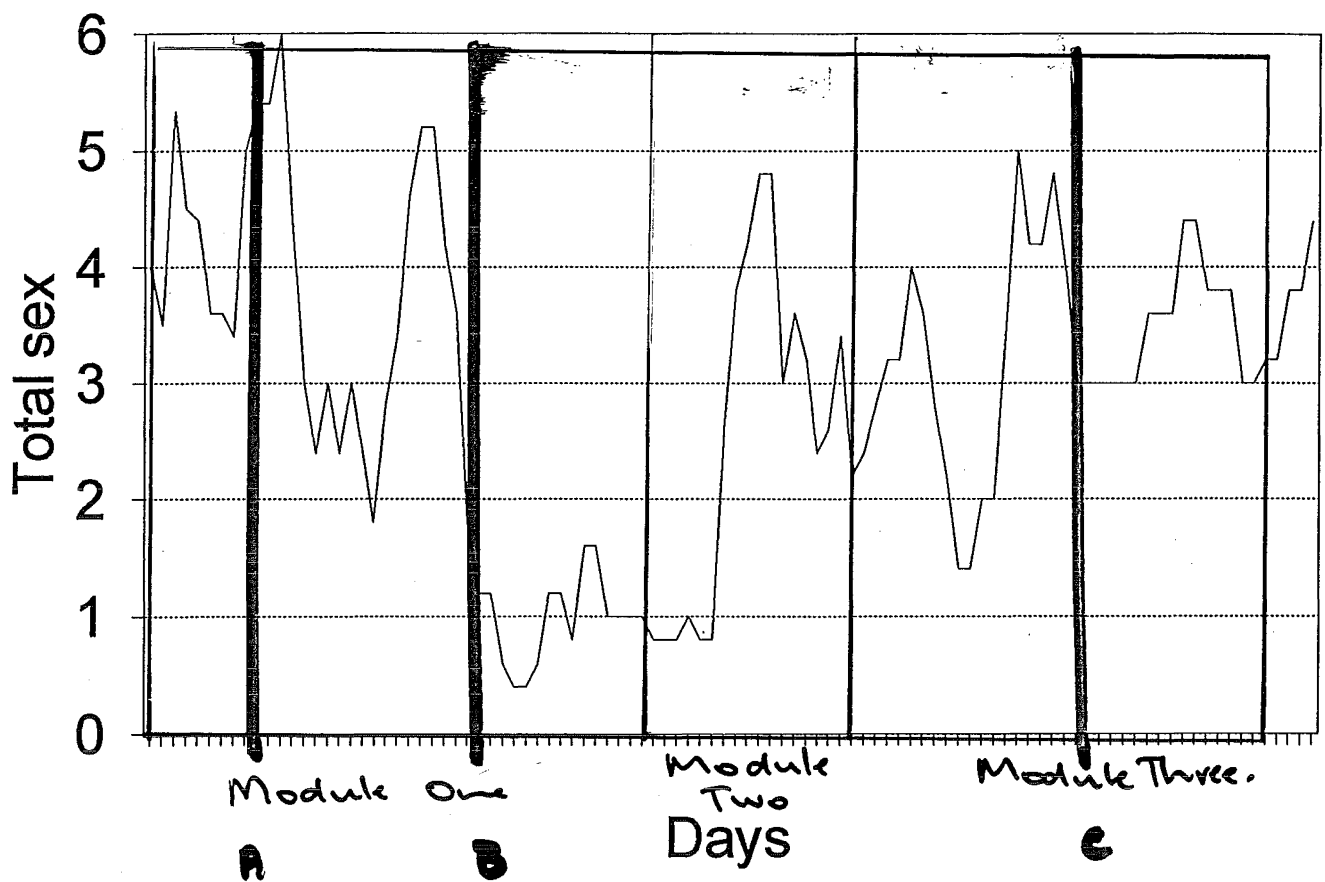


"Hotseat"

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 7.

Sub 7 Total 2



- 1 seat "
- A Cognitive Distortions Offence Cycle 1
 - B Cognitive Distortions Offence Cycle 2
 - C Victim Impact / Empathy.

SUBJECT EIGHT

There are only three significant correlations amongst the subscales, they all correlate with the total score apart from scale 4, lonely-sociable. None of the relationships with total two are significant, several are negative.

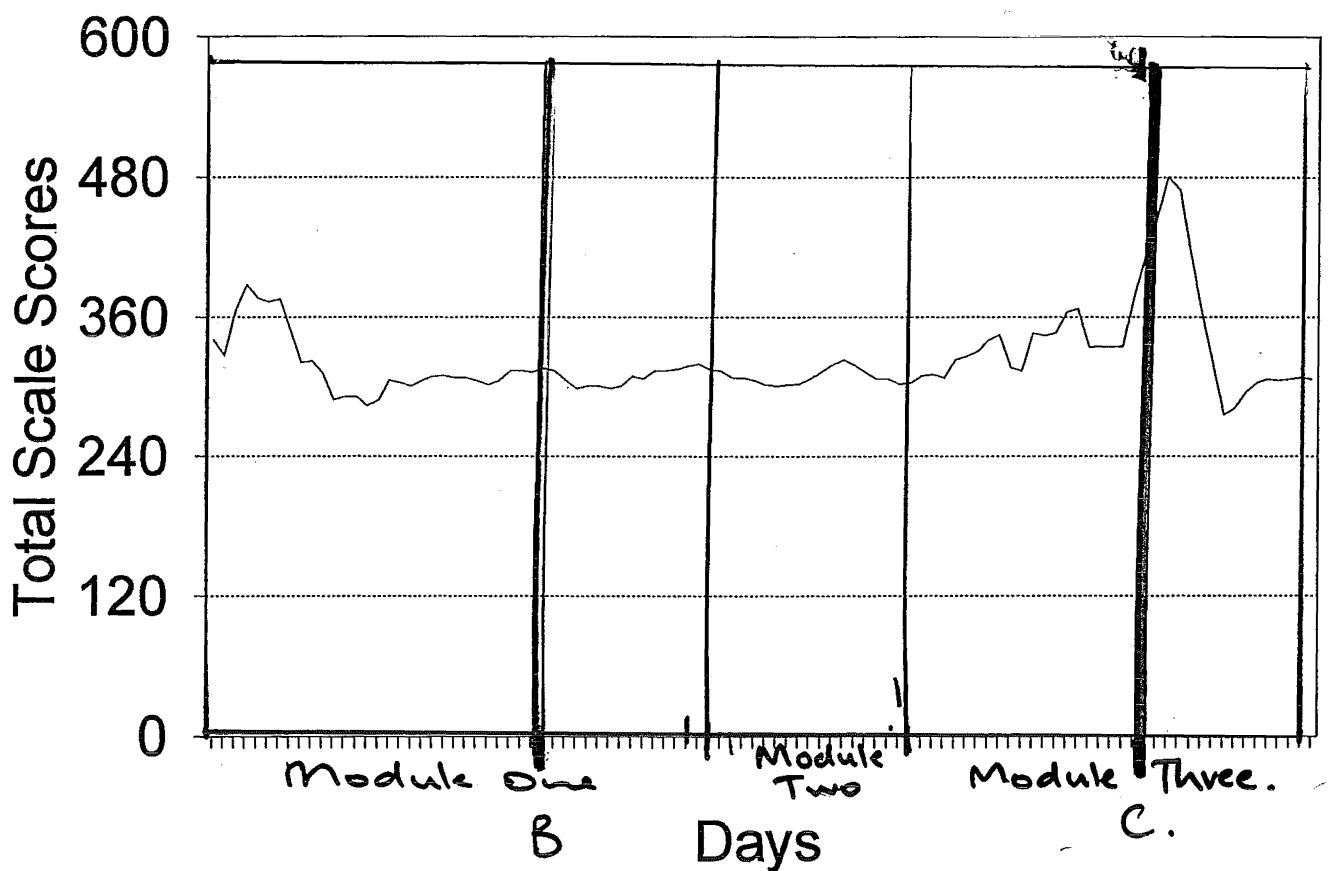
The graphs range between a narrow range, during module one and two, with a n increase in negative affect in the last module at victim impact/victim empathy. The total decreases markedly after point B and C.

SUBJECT No 8

	HAPPY/SAD	SOCIABLE/ LONELY	CALM/ ANGRY	GOOD TEMP/ BAD TEMP	PROUD/ ASHAMED	PEACEFUL / WORRIED	TOTAL 1 EMOTION SCORES	TOTAL 2 - SUM OF SEX SCORES
HAPPY/SAD	1.000							
SOCIABLE/LONELY	0.469	1.000						
CALM/ANGRY	0.742	0.617	1.000					
GOOD TEMP/ BAD TEMP	0.139	0.508	0.070	1.000				
PROUD/ ASHAMED	0.548	0.511	0.630	0.413	1.000			
PEACEFUL/WORRIED	0.774	0.650	0.754	0.186	0.534	1.000		
TOTAL 1 EMOTION SCORES	0.839	0.780	0.830	0.470	0.785	0.873	1.000	
TOTAL 2 - SUM OF SEX SCORES	0.317	-0.226	-0.050	-0.237	--0.048	-0.023	-0.017	1.000

Subject 8

Subject 8 Total 1

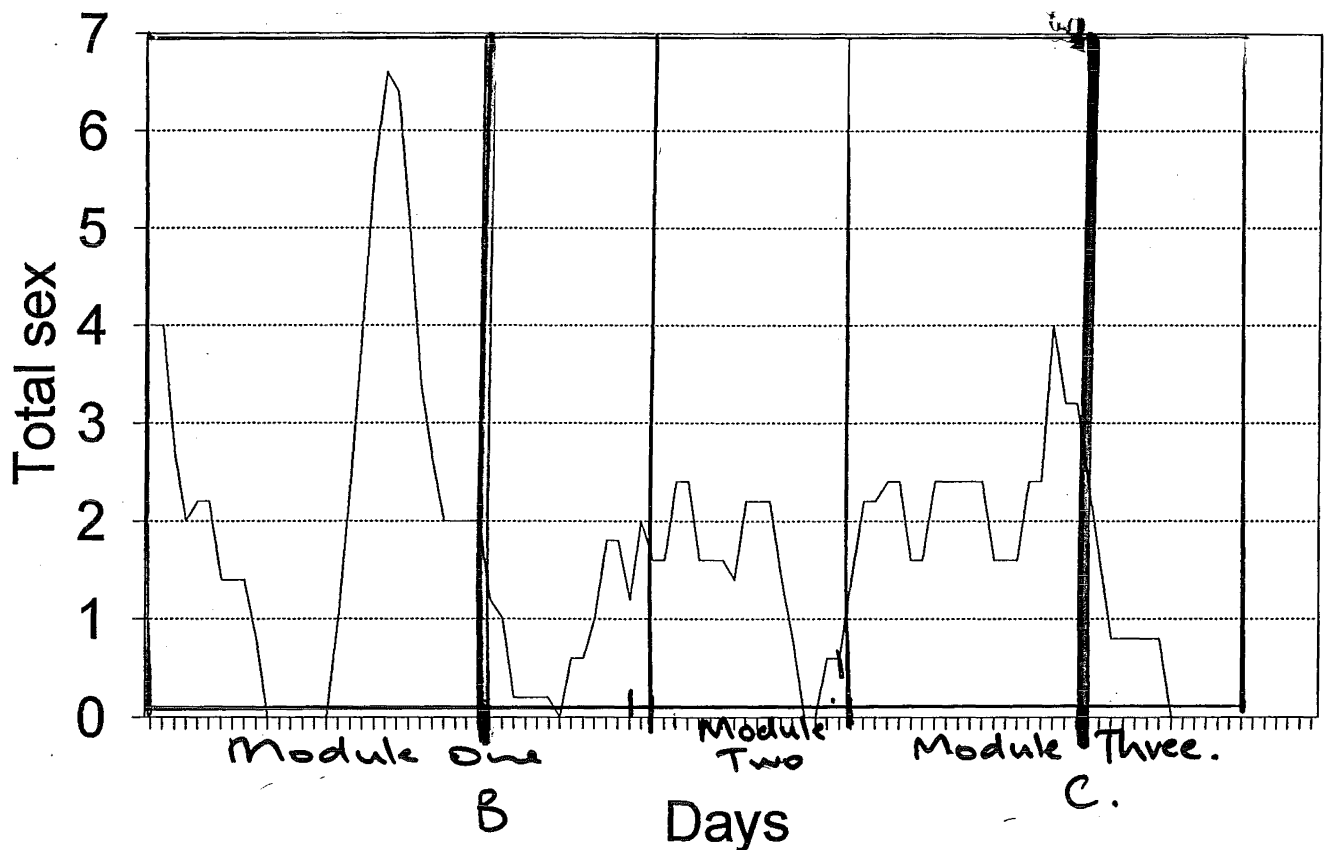


Hotseat[™]

- A - Not recorded.
- B - Cognitive Distortions Offence Cycle 2
- C - Victim Impact Empathy

Subject 8

Sub 8 Total 2



test"

A - Not recorded.

B - Cognitive Distortions Offence Cycle 2

C - Victim Impact Empathy

SUBJECT NINE

There are mostly high correlations between the subscales, all the relationships with total one are significant. None of the correlations with total 2 are significant. All are negative.

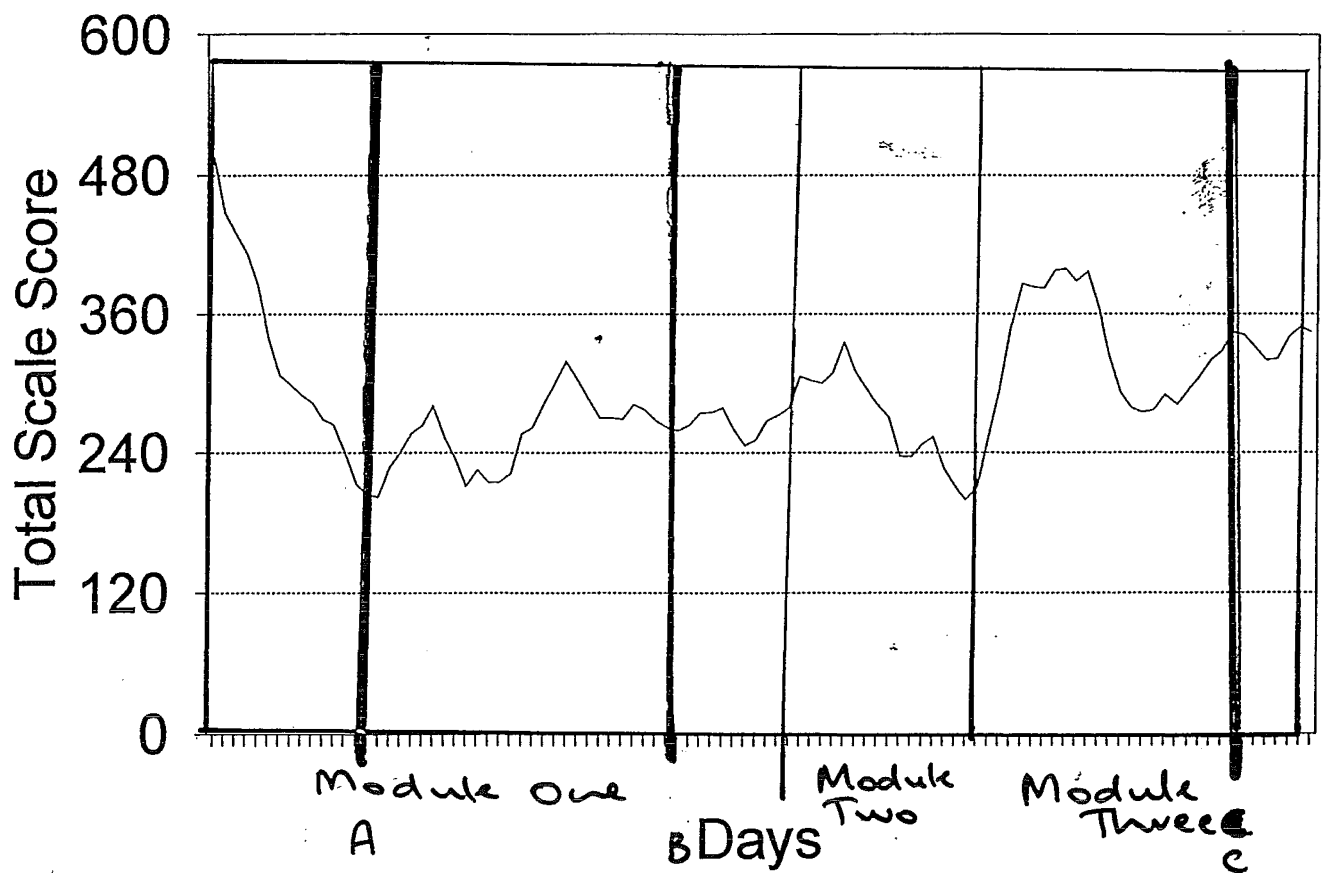
The graphs (scales and total one) show a decrease in negative affect to point A in module one and a rapid increase at the beginning of module three. The graph of total two shows decreases after point A and point B. There is an increase during module two which declines at module three and then increases.

SUBJECT No 9

	HAPPY/SAD	SOCIABLE/ LONLEY	CALM/ ANGRY	GOOD TEMP/ BAD TEMP	PROUD/ ASHAMED	PEACEFUL/ WORRIED	TOTAL 1	TOTAL SEX
HAPPY/SAD	1.000							
SOCIABLE/LONLEY	0.718	1.000						
CALM/ANGRY	0.617	0.588	1.000					
GOOD TEMP/ BAD TEMP	0.845	0.670	0.606	1.000				
PROUD/ASHAMED	0.501	0.396	0.740	0.521	1.000			
PEACEFUL/WORRIED	0.794	0.659	0.750	0.828	0.571	1.000		
TOTAL 1	0.899	0.791	0.842	0.887	0.718	0.919	1.000	
TOTAL SEX	-0.205	-0.080	-0.277	-0.090	-0.135	-0.082	-0.174	1.000

Subject 9.

Subject 9 Total 1

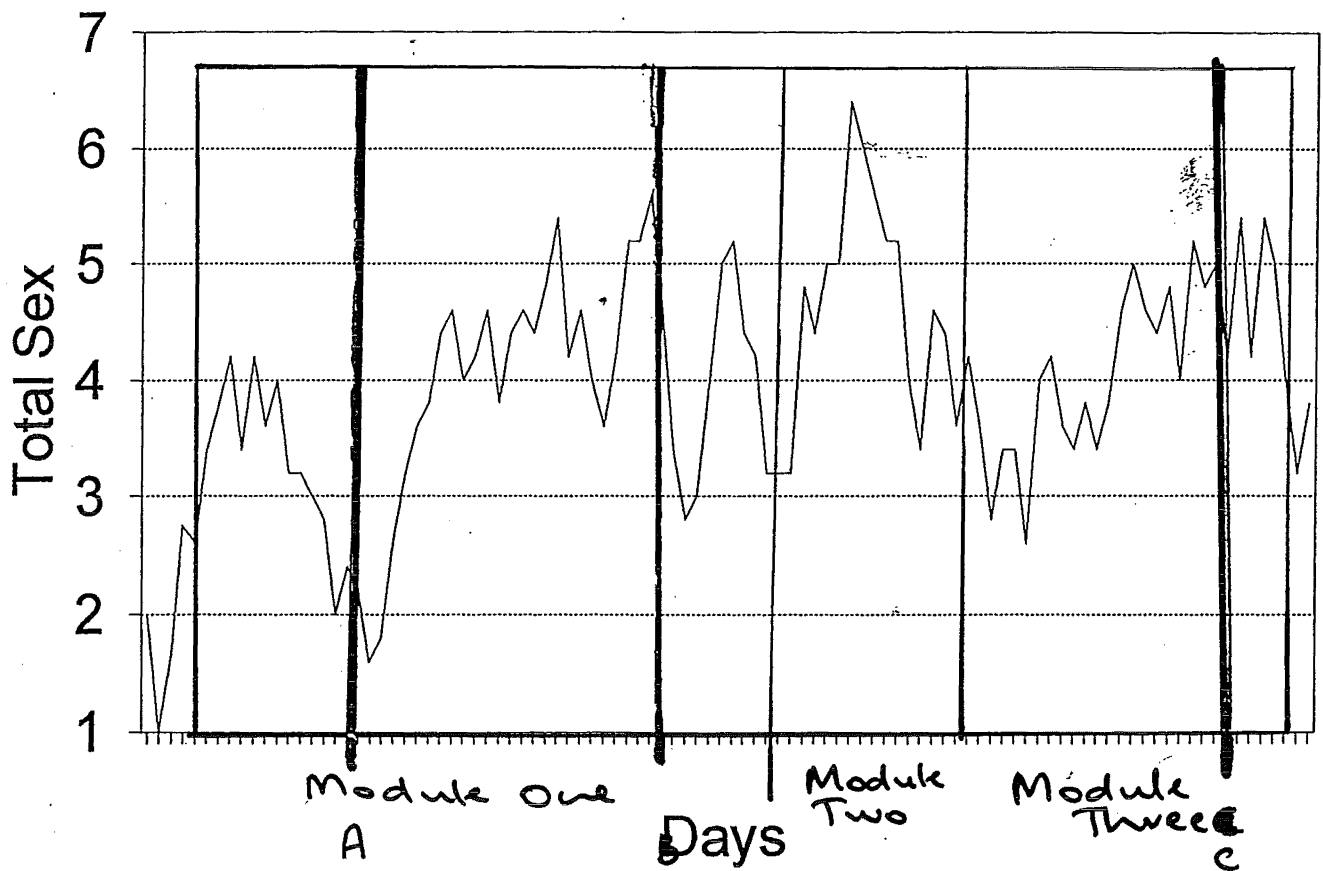


'Hotseat'

- A Cognitive Distortions offence Cycle 1
- B Cognitive Distortions offence Cycle 2
- C Victim Impact / Empathy.

Subject 9.

Subject 9 Total 2



'Holocat'

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

SUBJECT TEN

There was high degree of correlation among the first three scales, they do not correlate significantly with the last two, but these two scales correlate with each other. All scales apart from scale 5 (proud/ashamed) correlated with the total. None of the relationships were significant with total two, all were negatively related.

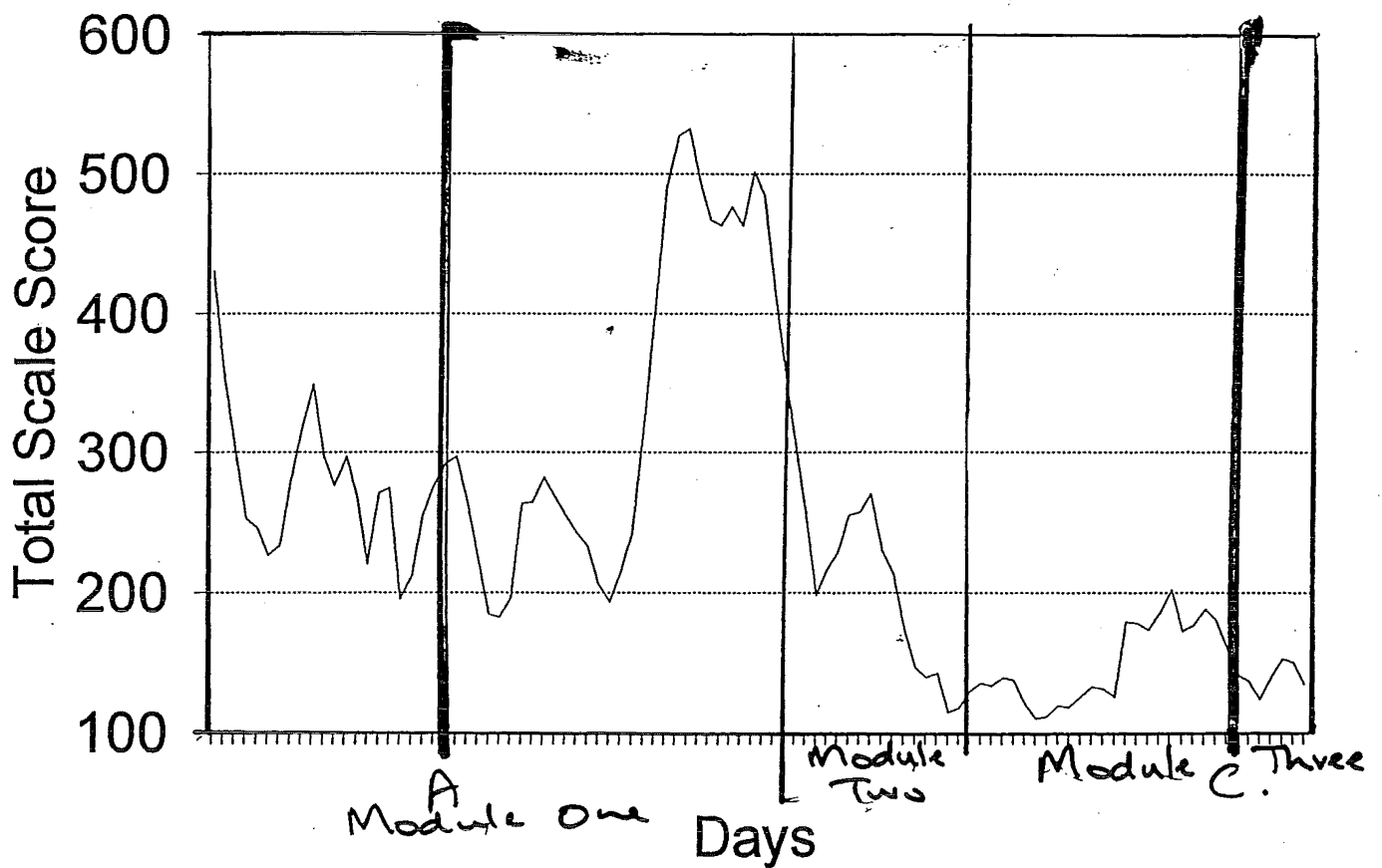
The graphs showed an increase in negative affect at point A, point C was not recorded but there was a rapid and sustained increase in the levels of negative affect over all the emotion scales at the end of module one, which decreased during module two, and built again through module three, but only to a minor extent.

SUBJECT No 10

	HAPPY/SAD	SOCIABLE/ LONELY	CALM/ ANGRY	GOOD TEMP/ BAD TEMP	PROUD/ ASHAMED	PEACEFUL / WORRIED	TOTAL 1 EMOTION SCORES	TOTAL 2 - SUM OF SEX SCORES
HAPPY/SAD	1.000							
SOCIABLE/LONELY	0.861	1.000						
CALM/ANGRY	0.963	0.922	1.000					
GOOD TEMP/ BAD TEMP	0.958	0.895	0.989	1.000				
PROUD/ASHAMED	0.498	0.569	0.461	0.420	1.000			
PEACEFUL/WORRIED	0.560	0.633	0.543	0.519	0.859	1.000		
TOTAL 1 EMOTION SCORES	0.955	0.948	0.969	0.954	0.645	0.716	1.000	
TOTAL 2 - SUM OF SEX SCORES	-0.488	-0.263	-0.172	-0.134	-0.426	-0.488	-0.286	1.000

Subject 10

Subject 10 Total 1

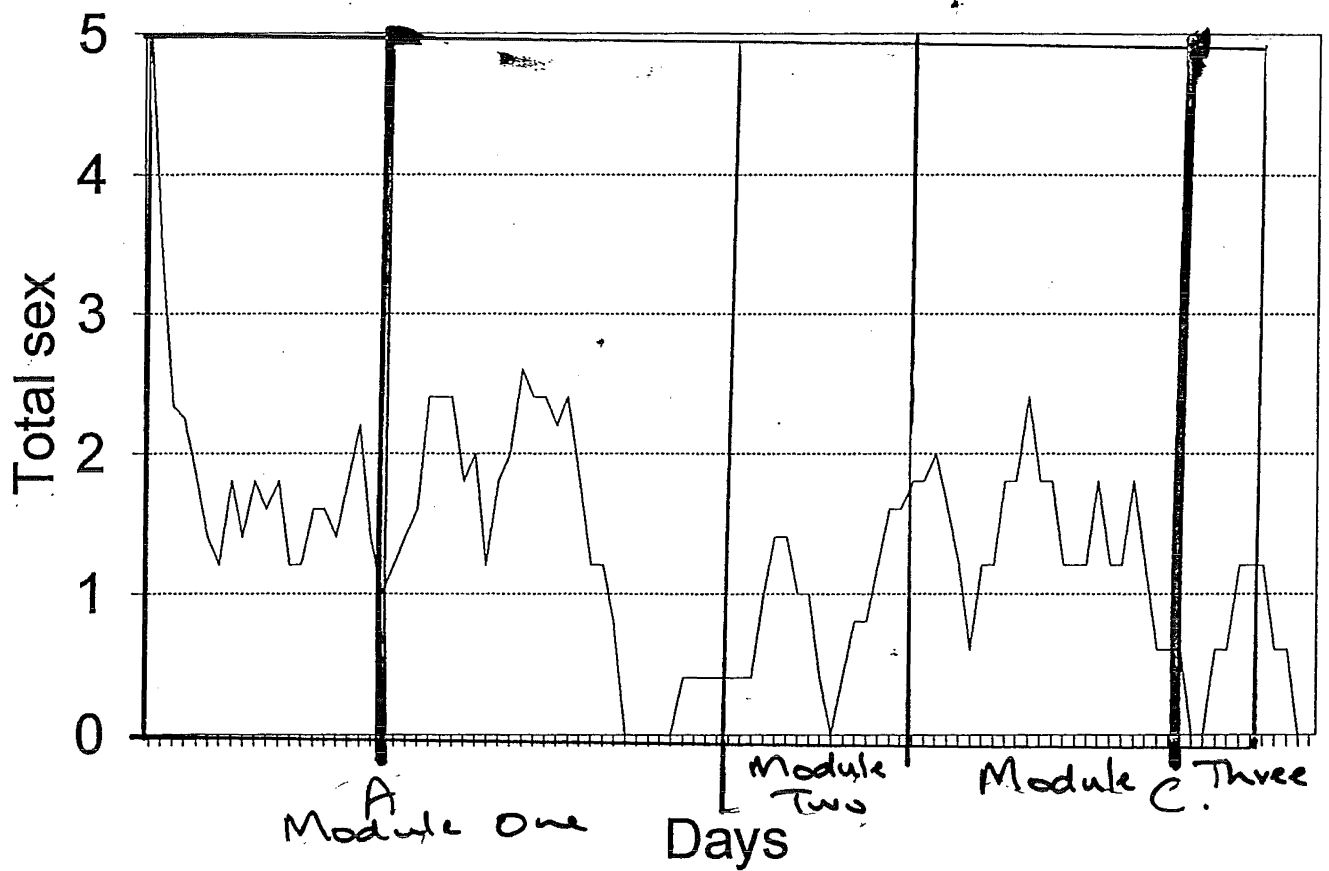


"Absent"

A. Cognitive Distortions. Offense Cycle
B. Not Recorded.
C. Victim Impact/Empath.

Subject 10

Subject 10



"Hotseat"

A. Cognitive Distortions. Offense Cycle
B. Not Rewarded.
C. Victim Impact/Empath.

SUBJECT ELEVEN

There were only two significant correlations between the subscales and they were extremely high. Scale one (happy/sad) correlated with scale two (sociable/lonely), and scale 3 (calm/angry) with scale 4 (good tempered/bad tempered). These latter two scales were the only ones to correlate significantly with the total.

The graphs reveal that scales 1 (happy/sad), 2 (lonely/sociable), 5 (proud/ashamed) and 6 (peaceful/worried) were at the upper end of the range of negative affect i.e. 80-100, throughout the three modules. Points A, B, and C were not recorded.

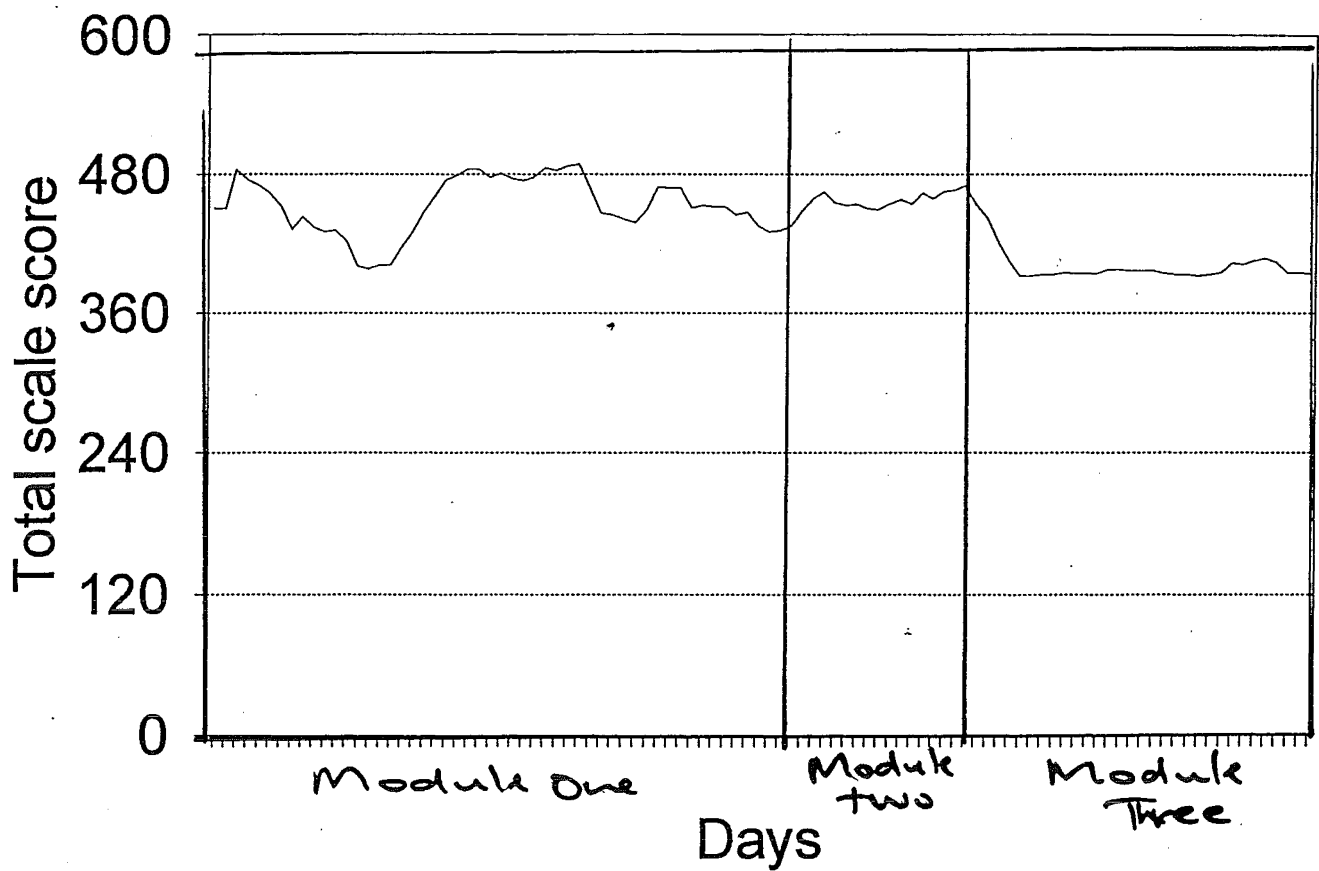
Scale 3 (calm/angry) and scale 4 (good tempered/bad tempered) were within the 0-60 range, showed an increase in negative affect in the second part of module two which was sustained through module two and declined markedly through module three. This individuals BDI scores were extremely high throughout the data collection period. Total two showed increase towards the end of module one, no recordings at the beginning of module two, an increase through to the latter part of module three, and again no recordings in the latter stages of module three.

SUBJECT No 11

	HAPPY/SAD	SOCIABLE/ LONELY	CALM/ ANGRY	GOOD TEMP/ BAD TEMP	PROUD/ ASHAMED	PEACEFUL / WORRIED	TOTAL 1 EMOTION SCORES	TOTAL 2 - SUM OF SEX SCORES
HAPPY/SAD	1.000							
SOCIABLE/LONELY	0.919	1.000						
CALM/ANGRY	-0.267	-0.299	1.000					
GOOD TEMP/ BAD TEMP	-0.367	-0.419	0.946	1.000				
PROUD/ASHAMED	0.298	0.199	-0.453	-0.412	1.000			
PEACEFUL/WORRIED	0.387	0.471	-0.080	-0.146	0.027	1.000		
TOTAL 1 EMOTION SCORES	-0.093	-0.137	0.970	0.942	-0.363	0.043	1.000	
TOTAL 2 - SUM OF SEX SCORES	-0.414	-0.507	0.174	0.229	-0.350	-0.537	0.062	1.000

Subject 11.

Subject 11 Total 1

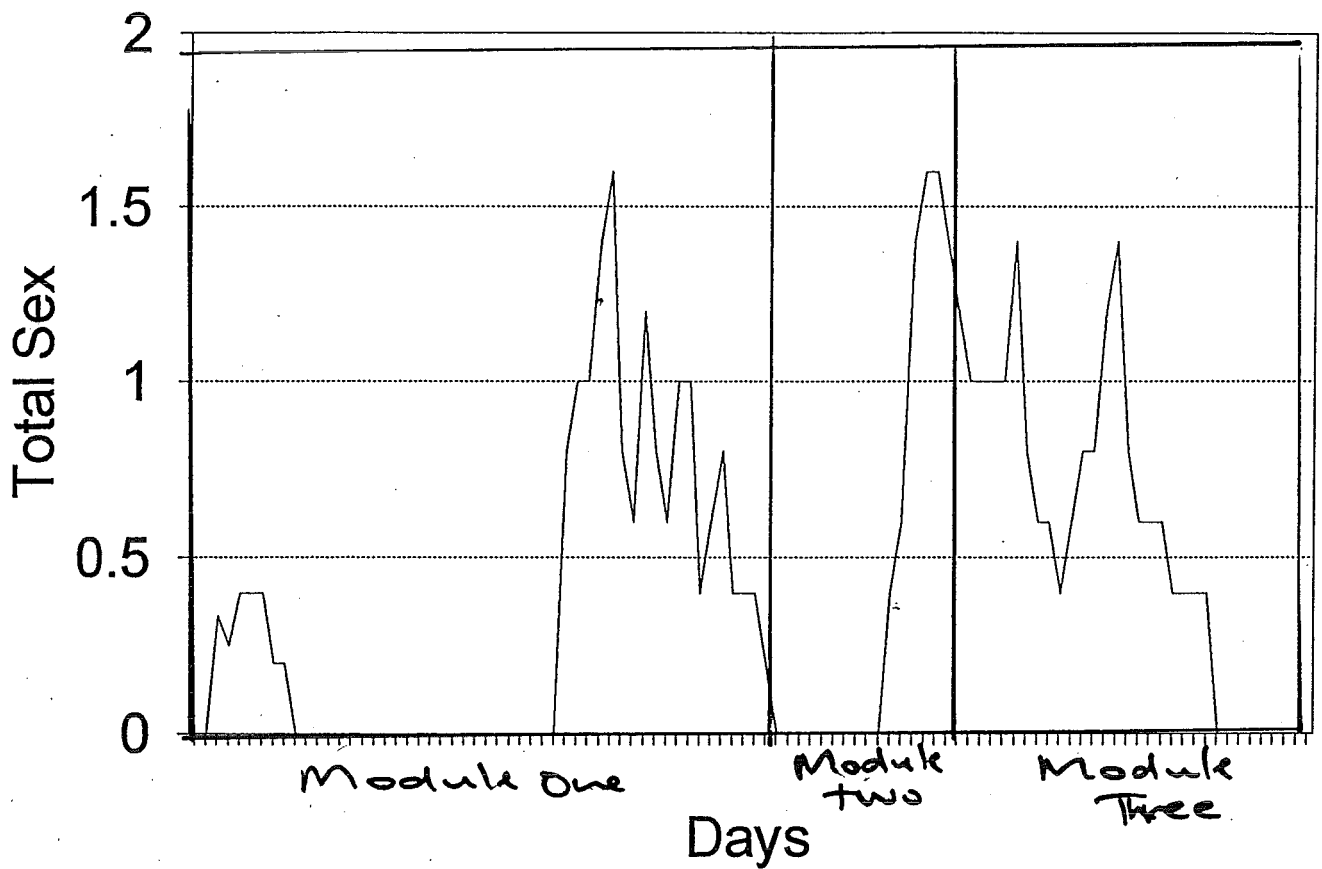


"Hotseat"

A Not Recorded
B Not Recorded
C Not Recorded.

Subject 11.

Subject 11 Total 2



"Hotseat"

A Not Recorded
B Not Recorded
C Not Recorded.

SUBJECT TWELVE

There is good correlation between the subscales, apart from scale 4 (good tempered/bad tempered). There is good correlation between the sub scales and the total, apart, except for scale 4. There are no significant correlations with total 2.

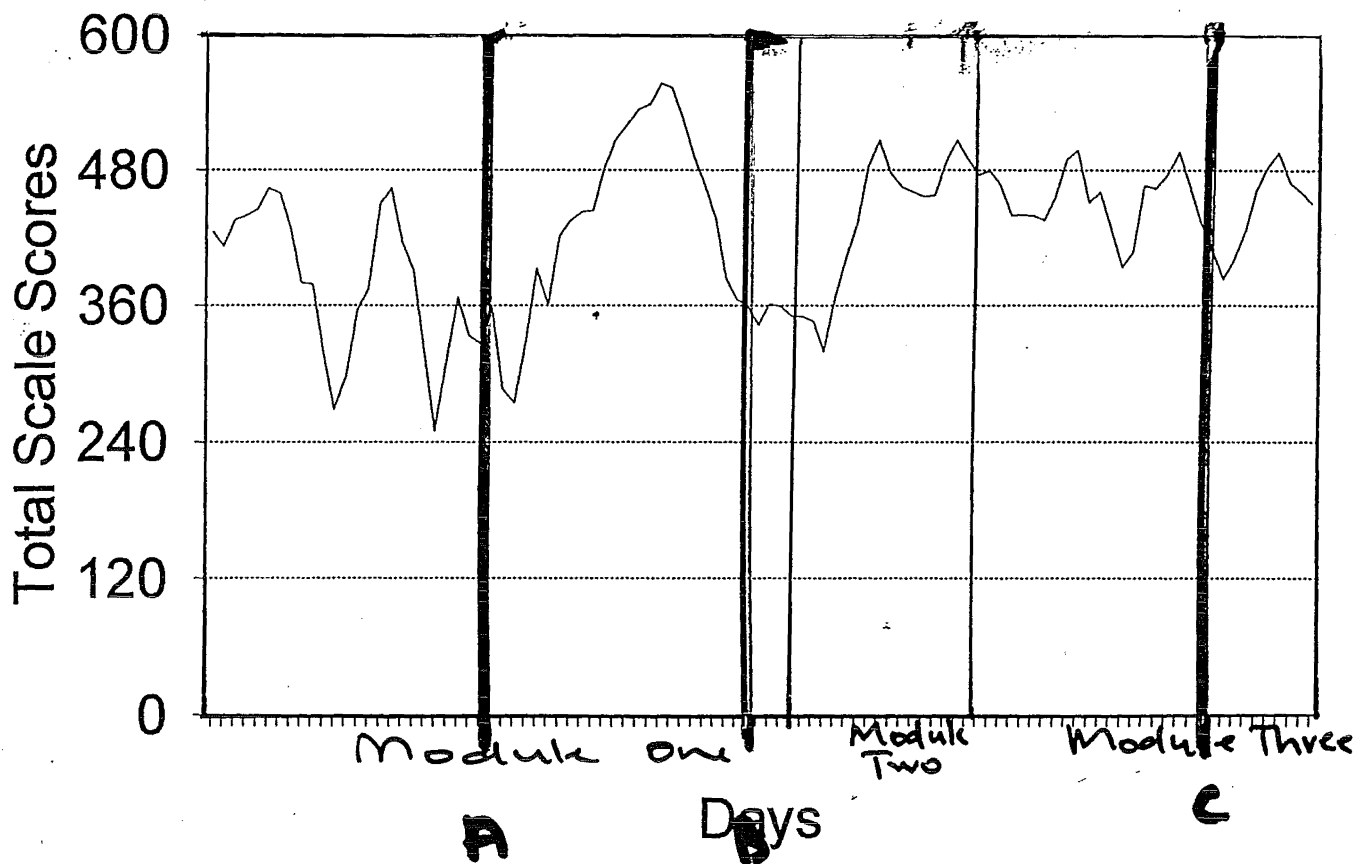
The graphs show high levels of negative affect which decrease at points A, B, and C. the negative affect score reaches its highest peak between a, and B. Total two declines from point A until the end of module one, it then increases to point C, where it drops off markedly and then increases to high levels over the next 3-4 days.

SUBJECT No 12

	HAPPY/SAD	SOCIABLE/ LONELY	CALM/ ANGRY	GOOD TEMP/ BAD TEMP	PROUD/ ASHAMED	PEACEFUL / WORRIED	TOTAL 1 EMOTION SCORES	TOTAL 2 - SUM OF SEX SCORES
HAPPY/SAD	1.000							
SOCIABLE/LONELY	0.869	1.000						
CALM/ANGRY	0.833	0.832	1.000					
GOOD TEMP/ BAD TEMP	0.378	0.286	0.341	1.000				
PROUD/ASHAMED	0.851	0.834	0.862	0.493	1.000			
PEACEFUL/WORRIED	0.694	0.692	0.754	0.135	0.774	1.000		
TOTAL 1 EMOTION SCORES	0.928	0.903	0.918	0.511	0.957	0.808	1.000	
TOTAL 2 - SUM OF SEX SCORES	0.069	0.241	-0.083	-0.099	-0.056	-0.169	-0.012	1.000

Subject 12.

Subject 12 Total 1

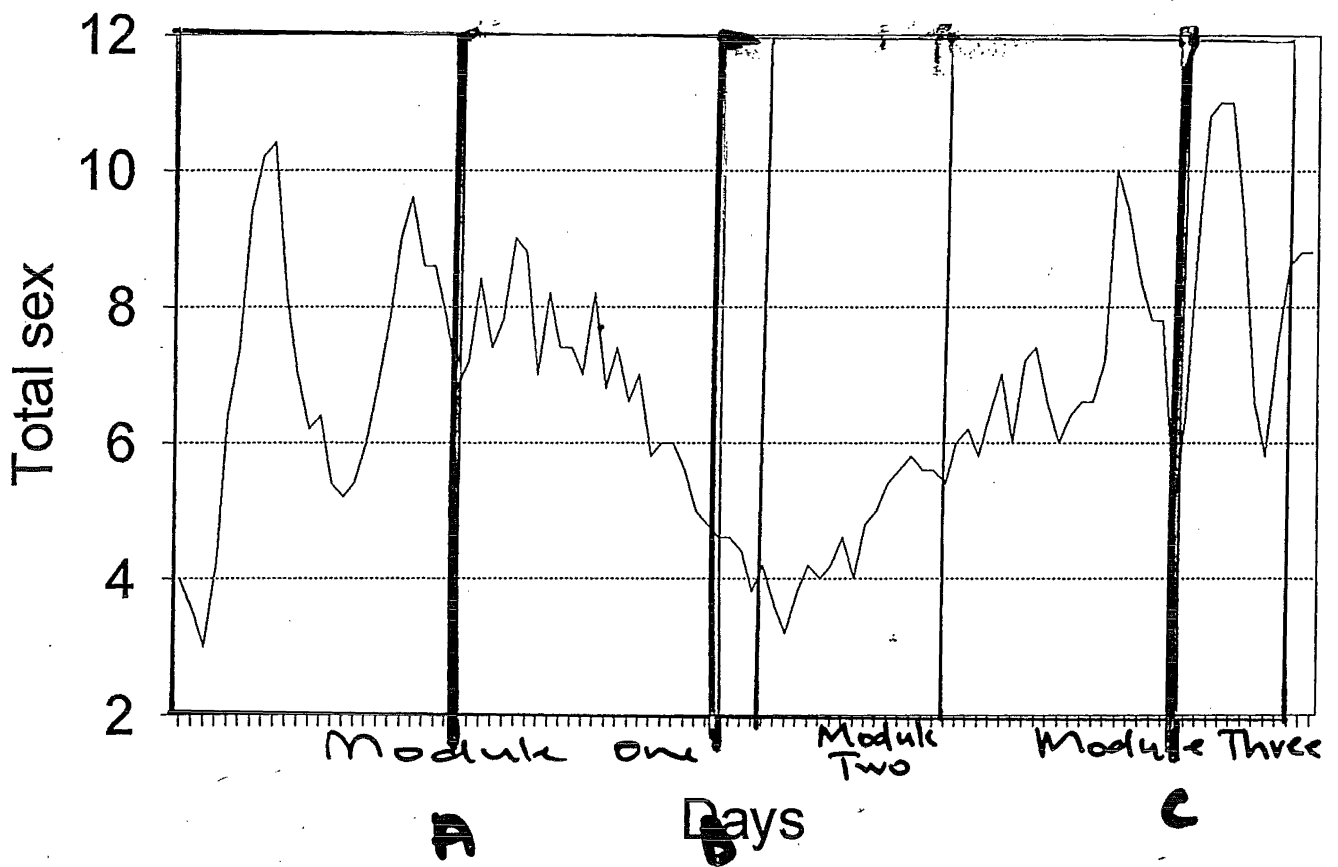


Hot seat

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 12.

Subject 12 Total 2



Hot seat

- A Cognitive Distortions offence Cycle 1
- B Cognitive Distortions offence Cycle 2
- C Victim Impact / Empathy.

SUBJECT THIRTEEN

The correlation between the subscales and the total one were mostly significant apart from scale 5 (proud/ashamed) which mostly approached significance.

The correlations between total 2 and the scales and total one approached significance at $p < .05$ for all measures, except scale three (calm/angry), but there are only measures recorded in module three..

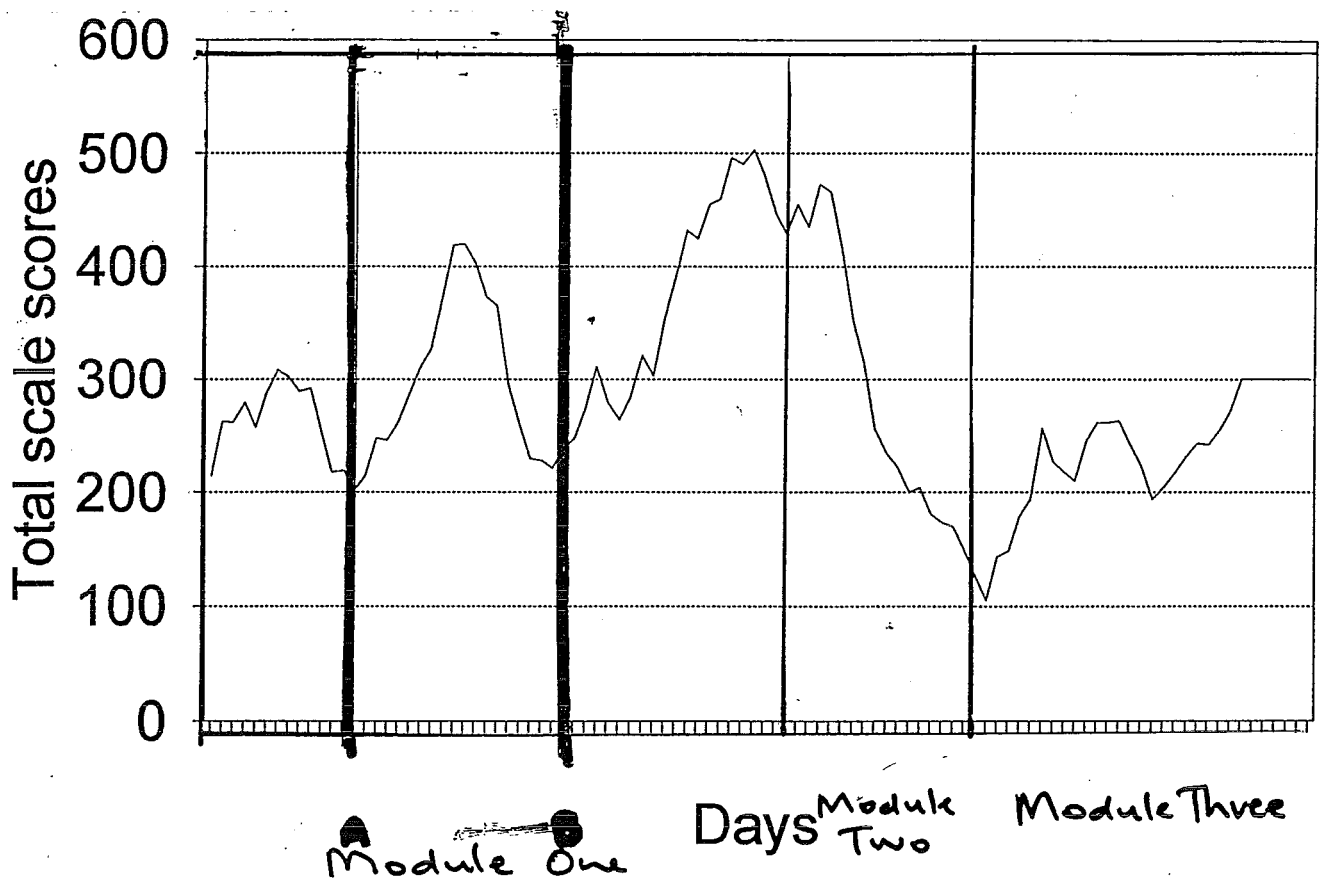
The graphs for mood scores show negative affect drops at points A and B, increases from point B to the end of the modules, declines over module two and increases again in the third module but not to the levels previously recorded.

SUBJECT No 13

	HAPPY/SAD	SOCIABLE/ LONELY	CALM/ ANGRY	GOOD TEMP/ BAD TEMP	PROUD/ ASHAMED	PEACEFUL / WORRIED	TOTAL 1 EMOTION SCORES	TOTAL 2 - SUM OF SEX SCORES
HAPPY/SAD	1.000							
SOCIABLE/LONELY	0.815	1.000						
CALM/ANGRY	0.871	0.827	1.000					
GOOD TEMP/ BAD TEMP	0.789	0.763	0.899	1.000				
PROUD/ASHAMED	0.579	0.689	0.646	0.453	1.000			
PEACEFUL/WORRIED	0.643	0.753	0.730	0.541	0.957	1.000		
TOTAL 1 EMOTION SCORES	0.886	0.922	0.945	0.845	0.812	0.871	1.000	
TOTAL 2 - SUM OF SEX SCORES	-0.478	-0.580	-0.421	-0.531	-0.484	-0.499	-0.563	1.000

Subject 13

Subject 13 Total 1

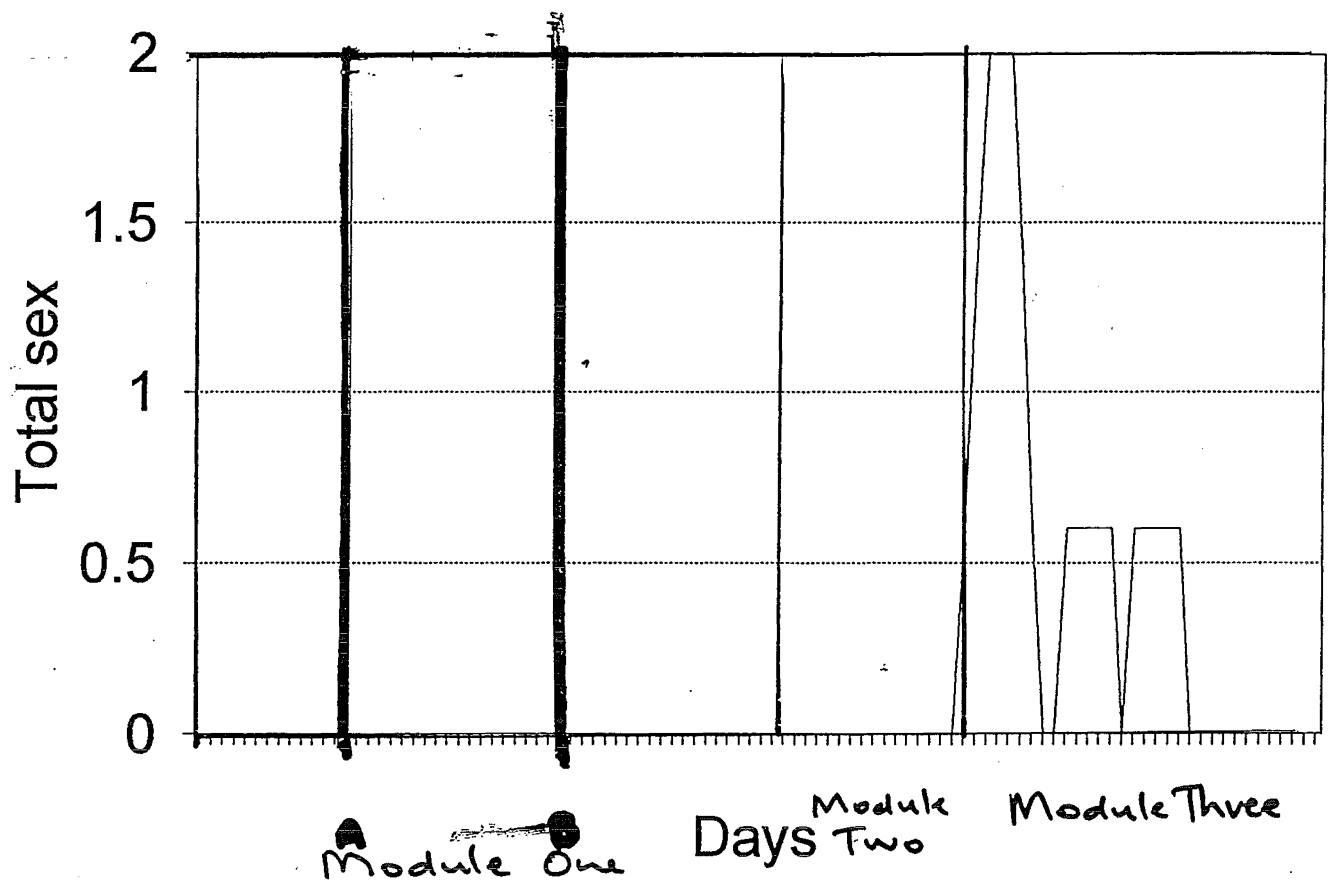


"Hotseat"

- A Cognitive Distortions Offence Cycle One
- B Cognitive Distortions Offence Cycle two
- C Not Recorded

Subject 13

Subject 13



"Hotseat"

- A Cognitive Distortions Offence Cycle One
- B Cognitive Distortions Offence Cycle two
- C Not Recorded

SUBJECT FOURTEEN

All the correlations between the matrices are significant and high apart from scale 5 (proud/ashamed) which approached these levels. There was no relationship between total 2 and the other measures.

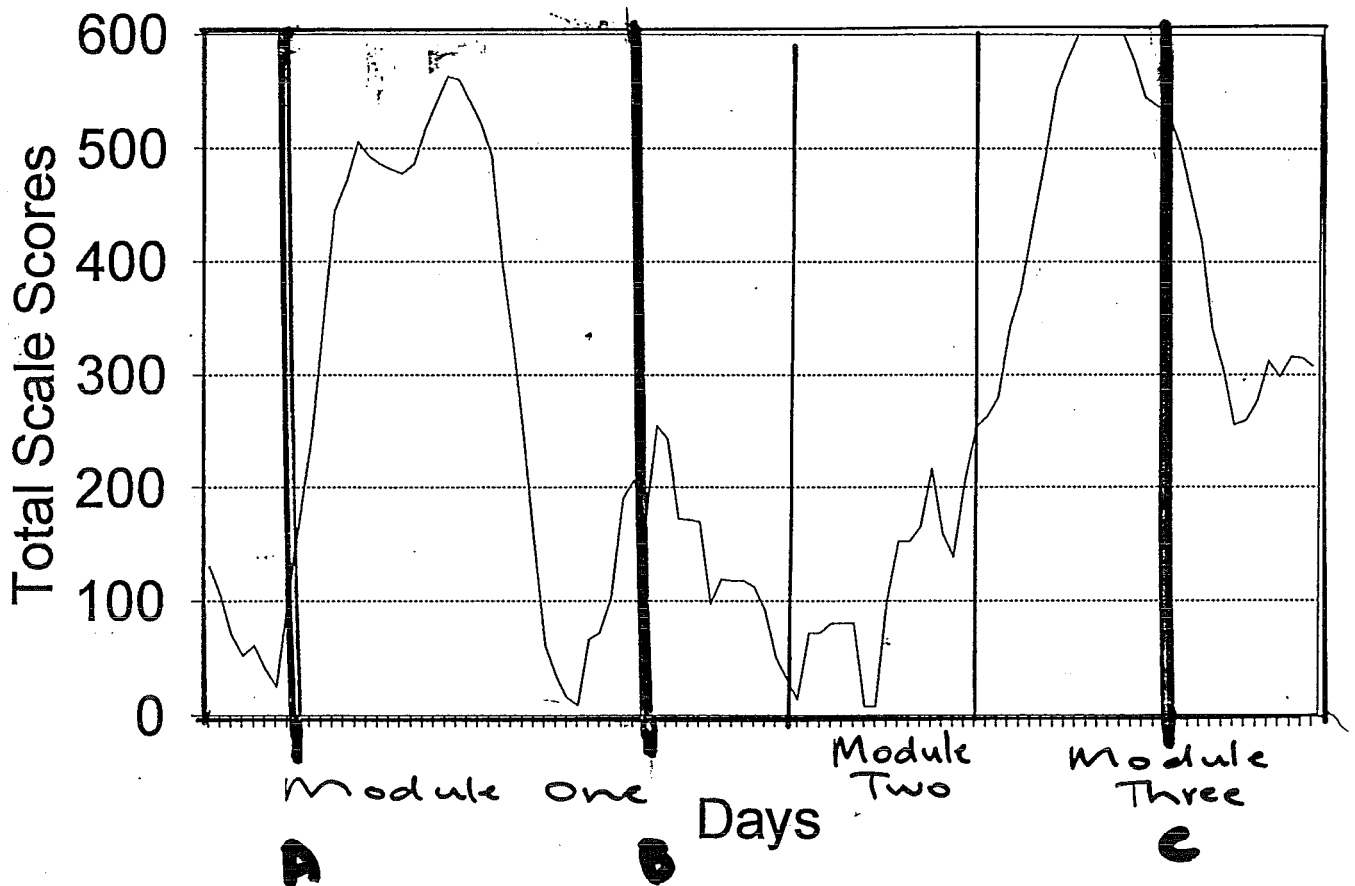
The graphs show very high negative affect after point A, which decreased to zero and then reached another peak at point B, this second peak was about half that of the first. The levels then remained low until the third module when they reached the total measure of negative for several days and declined after point c.

SUBJECT No 14

	HAPPY/SAD	SOCIABLE/ LONELY	CALM/ ANGRY	GOOD TEMP/ BAD TEMP	PROUD/ ASHAMED	PEACEFUL / WORRIED	TOTAL 1 EMOTION SCORES	TOTAL 2 -SUM OF SEX SCORES
HAPPY/SAD	1.000							
SOCIABLE/LONELY	0.889	1.000						
CALM/ANGRY	0.864	0.789	1.000					
GOOD TEMP/ BAD TEMP	0.810	0.798	0.924	1.000				
PROUD/ASHAMED	0.668	0.516	0.684	0.560	1.000			
PEACEFUL/WORRIED	0.857	0.912	0.823	0.812	0.556	1.000		
TOTAL 1 EMOTION SCORES	0.948	0.917	0.941	0.906	0.739	0.925	1.000	
TOTAL 2 - SUM OF SEX SCORES	-0.020	-0.041	0.051	-0.156	0.037	0.078	-0.000	1.000

Subject 14

Subject 14 Total 1



"Hotseat"

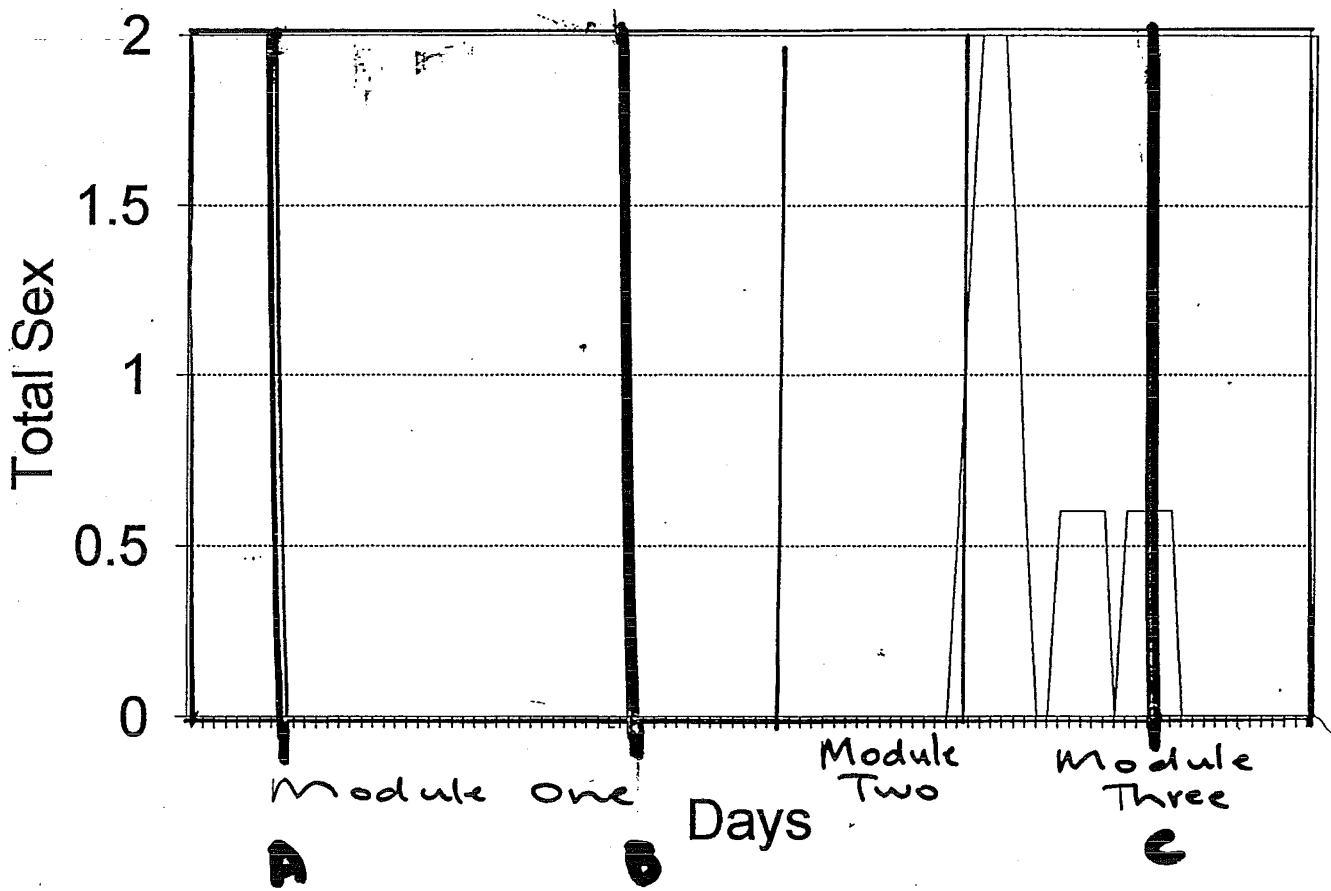
A

B

C

Subject 14

Subject 14 Total 2



"Hotseat"

A
B
C

SUBJECTS DATA INCLUDED IN STUDY

As mentioned in the method section, three of the men who returned data were not included because they did not comply with the requirements. Two of these men filled out only the scales which they chose each day, even after the researcher reminded them that the task required them to fill out each of the scales. They were not consistent about the scales that they chose to fill in and so it is not possible to present their data. Another man wrote how he was feeling on some of the scales each day and continued to do so even after the expected task was discussed with him. The researcher was not able to establish whether this was passive aggressive avoidance behaviour by any or all of these three subjects, or whether the task was beyond them because they were not able to identify and express their emotional experience.

EMOTION SCORES

The uses of the scales of positive - negative mood did track the individuals experience in group over the course of therapy. Two of the (subjects 2 & 4) had extremely high correlations between all subscales and the totals, which may indicate that their emotional experience of themselves is that all their positive - negative emotions move in concert with one another.

Two other men (subjects 5 & 11) showed very little correlation between the scales and total. The interesting thing about these men is that they have very little in the fluctuations of their reported total emotional state over the 100 days with no visually significant peaks or troughs. They are two of the four men whose graphs flattened out over the victim impact/empathy module. This may imply that these men have difficulty recognising their own and others emotional states. The other two men in this profile who recorded little change in affect during module three are subjects 3 & 6. Subject 3 consistently reported positive emotional experience after the initial phase of module One. Subject 6 reported major negative peaks of mood in the first two modules but declined through module three.

The overall results indicate that the men in treatment experience fluctuations in their emotional states which can become quite negative and this may persist over several days, even weeks. The results indicate that some of the mens emotional states are related to the modules and that being in the "hotseat" has a significant impact and that their report of negative mood increases around that time.

SEXUALITY SCORES

Three of the men reported the most frequent sexual activity around point C, (victim impact/empathy) which then declined rapidly after that point.

We would expect that sexual thinking behaviour reported would increase after the delivery of the satiation techniques in the second module. The results do not support the contention that negative mood is associated with increases in sexual thinking and behaviour, that is, fantasies and masturbation.

This experimental research design could be redeveloped in future research.

DISCUSSION

The relationship between negative affect and sexual preoccupation was not demonstrated by this research project, although some association can be seen in the graphs of the data particularly around the time that the individual was disclosing their issues to the group. This study may indicate that a treatment effect is that men do not engage in the relapse process, i.e. negative affect, deviant fantasies, passive offence planning, while their attitudes and beliefs, distorted thinking and denial is being actively challenged, and that the challenge for them in Relapse Prevention is to maintain this treatment gain.

The results did show incidences of extreme negative affect and rapid shifts in mood during the first modules of the programme. For most of the men there was a noticeable shift in affect, around the time they were in the "hotseat". Some of the subjects were less able to identify and express their emotional experience, further investigation of these individuals would be a useful, as this limitation will be a handicap in their understanding of the offence chain.

It is not surprising that there is no significant changes in the BDI, STAI, and STAXI results for the total number of men over the 100 days of data collection. The mood management module is not delivered to the men until the next phase of the programme. The difference between the groups on BDI, STAI (trait), and STAXI (trait) has implications for treatment providers about how the mood levels of negative affect are managed for the men in treatment, and the cost to the therapist when the several of the men in group are predisposed to negative mood states.

The capacity of an individual to cope with his environment. The ecological fit between man and his culture and the experience of the individual, is the theme of much of human existence. When one considers the issues of treatment for child sexual offenders, the challenge for Psychology is to provide an opportunity for individuals who have developed deviant and dysfunctional behaviours, attitudes and belief systems to engage in a process which will allow them to change. The investigation of this thesis has been largely experimental in nature based on the theoretical constructs which operate in a cognitive-behavioural, group based therapy programme for caught and convicted child molesters.

One important construct of this theory is that human behaviour exists along a continuum from functional and adaptive to dysfunctional and maladaptive. The men who present for treatment definitely have aspects of their behavioural repertoire which is at the far end of the dysfunctional and maladaptive. They themselves will admit that the opportunity to engage in treatment and address this aspect of their lives, allows them to reorientate themselves in the world. "That programme was the best thing I ever did", a personal communication of a programme graduate to the writer six months after he had completed his parole period. The process of engaging men in therapy and challenging them to re-evaluate their belief systems begins with the time period under consideration in this thesis. Emotions are allies in the process of therapeutic change (Safran & Greenberg). The ability of the subjects to recognise their emotional experience and the role it plays in their cognitive functioning and behavioural tendencies, and to take responsibility for how they manage these aspects of their lives. It is a goal of treatment and is essential for effective implementation of the maintenance phase of Relapse Prevention.

The period of time when the data was collected was the initial phase of the programme; cognitive distortions, sexual reconditioning and victim impact/empathy. The results provide some validation of the clinical impression of the treatment providers regarding the impact of the modules on the men in treatment. Those who deliver this intervention report that they are constantly challenged by the amount of negative affect that is generated during these modules. When one considers that several of the group members are coping with high levels of negative affect at any one time, it is not difficult to imagine the impact of their issues combined in the group process.

The therapy programme has a good liaison with the local Forensic Services, and there are effective procedures in place to render assistance to those individuals who need medical attention. Most of the referrals to the Forensic Services are for depression and anxiety disorders. All the men referred for assessment regarding mood adjustment have completed treatment.

LIMITATIONS

This research project was an experimental investigation and as such the limitations in hindsight are numerous. The design required a 100 days of data from each subject. The collection, sorting and recording of the data was extremely time consuming for the researcher. A pilot study over one of the modules would have been a good way to streamline the design, over a shorter period of time.

There were many influences operating on the subjects during the data collection phase, some of the men were coping with the initial stages of separation from their significant others and adjustment to the routine of

custodial environment. In order to assess the effect of the modules, the data collection time could be made at the end of therapy time daily for four days of therapy per week, with an instruction for the men to fill in the self report form as near to that time as possible when they were not in therapy. Also, a control group matched, for offence type, and length of time in prison, reporting data over the same time period, would give a clearer indication of the effect of the modules and the impact of being in the therapy "hotseat".

SUGGESTIONS

The therapists who undertake the task of delivering the therapy intervention have an extremely challenging task. This research project has focused on the emotional experience of the men who undertake the therapy programme. Consideration must also be made of the impact on the professional men and women who deliver the therapy programme and the toll it must make on them during the course of these modules. The therapy staff facilitate the attainment of therapy gains which promotes a shift for persons in treatment from their deviant, dysfunctional and maladaptive capacities. The cost to the persons delivering this intervention should be recognised in the conditions of work and remuneration available to the persons who staff these programmes

Coping with stress, negative affect and the promotion of lifestyle balance should be addressed throughout the programme but should perhaps be the focus of the therapeutic milieu of the therapy unit. The use of exercise to deal with processing emotions is already advocated in the by the therapy and custodial staff at the programme. In this way the expectation that men will have to deal with uncomfortable emotional states in order to make therapy change can be made implicit, as well as the message that coping with these

facets of life is manageable and achievable in a functional and adaptive manner.

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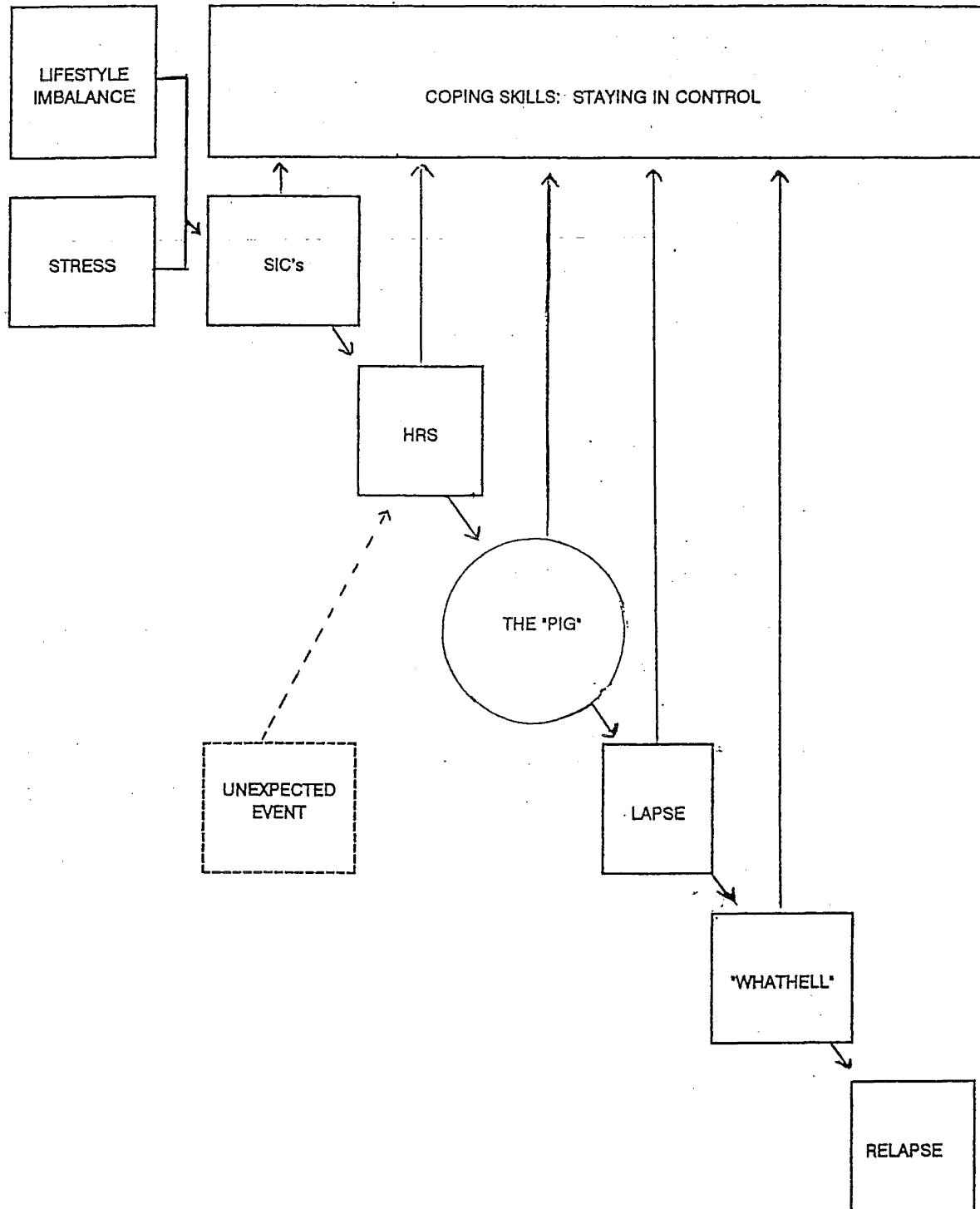
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B. The Relapse Process



DEMOGRAPHIC DATA

SUBJECT	AGE	ETHNICITY	MAJOR OFFENCE	LENGTH OF SENTENCE (MONTHS)	RELATIONSHIP TO VICTIM	GENDE R/AGE OF VICTIM
1	19	Caucasian	Sexual Violation	24	Known	M - 3YRS
2	24	Caucasian	Indecent * Assault	27	Stranger	F - 12-16 YRS
3	49	Caucasian	Sexual Violation	60	Known	F - 10YRS
4	43	Caucasian	Unlawful Sexual Intercourse	21	Known	F - 8-13YRS
5	35	Caucasian	Sexual Violation	30	Known	F - 10YRS
6	48	Caucasian	Indecent Acts	32	Known	M & F 3-12YRS
7	44	Caucasian	Indecent Acts	29	Known	F - 6-8YRS
8	28	Caucasian	Sexual Violation	52	Known	F - 9YRS
9	33	Caucasian	Sexual Violation	42	Known	F - 10YRS
10	27	Caucasian	Sexual Violation	90	Known	F - 11 YRS
11	41	Caucasian	Sexual Violation	48	Known	F - 9 YRS
12	33	Caucasian	Sexual Violation	72	Known	M - 12 YRS
13	38	Caucasian	Sexual Violation	35	Known	F - 8-9 YRS
14	57	Caucasian	Sexual Violation	36	Known	F - 9-11 YRS
			And			
			* Abduction			

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RESEARCH PROPOSAL

Name of researcher and/or supervisor: Nicola Scott/Steve Hudson

Title of project:

Twenty men undertaking the therapy programme are asked to self report daily their emotional state and degree of sexual preoccupation. The men will also be asked to complete the STAI, STAXI and BDI pre post testing and following, Cognitive Restructuring and Victim Impact modules. Data will be collected for 12 weeks.

Description of subject population:

Twenty male incarcerated child sex offenders who have volunteered to undertake therapy. Caucasian, Maori, Cook Island, Age range 18 - 70.

Number of subjects and time required:

Twenty subjects, daily 5 minutes for 12 weeks, re-administering BDI, STAI, STAXI, (1½ hours) x 3.

Concealment or deception - describe and provide justification (if relevant):

.....
.....
.....
.....
.....
.....
.....
.....

Please turn over

Risks - describe any risks associated with participation and follow-up procedures (if relevant):

This information will not be used for or against individuals to affect their release dates.

Debriefing procedure(s):

For the first two weeks, each subject will be interviewed every 2-3 days to see whether they are disturbed by the procedure, after that, weekly. The focus of the interview will be to gauge their fears and concerns. Each man will be able to discuss these matters with his therapist or group if he chooses as well as having access to the experimenter and supervisor.

Signature Michael Scott Date 1. 6. 93

PLEASE ATTACH A COPY OF THE COMPLETED CONSENT FORM

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DEPARTMENT OF PSYCHOLOGY

CONSENT FORM

Reason for the project:

The purpose of the study is to find out more about how the men undertaking therapy are getting on emotionally during therapy and also to investigate the amount of sexual thinking and behaviour that is going on for them.

Your tasks in this project:

Is to take 2-3 minutes each day and fill out the two forms as well as filling out 3 questionnaires after modules 1 and 2, and at the end of data collection.

Risks associated with participation:

There are no particular risks associated with this procedure. Information gained will not be used to affect Paroles or release dates.

Confidentiality:

You will be identified by a code agreed between yourself, me and my supervisor. The key will be destroyed once all the data have been collected.

Voluntary participation:

You are free to discontinue at any time.

Time required:

Daily report approximately 5 minutes x 12 weeks. Redo Assessment Questionnaires about 1½ hours, 3 times.

Name of researcher/supervisor

Nicola Scott / Dr S. Hudson

I agree to participate in the project described above, on the understanding that if at any time I wish to withdraw from the experiment I may, without prejudice, do so. All information collected will be confidential as will the identity of participants.

Name:

Signature: Date:.....

Please make a mark on the scales below which best indicates how you have been feeling over the past 24 hours

<i>happy</i>	_____	<i>sad</i>
<i>lonely</i>	_____	<i>sociable</i>
<i>angry (self)</i>	_____	<i>calm</i>
<i>bad tempered (others)</i>	_____	<i>good tempered (others)</i>
<i>proud</i>	_____	<i>ashamed/guilty</i>
<i>worried</i>	_____	<i>peaceful</i>

In a few words, why do you think you've been feeling the way you do?

.....

.....

.....

Please indicate on the self monitoring form how things have been for you sexually over the past 24 hours

Estimate by placing ticks in the boxes below how often you have experienced the following:

<i>Sexual urge</i>	<i>Sexual fantasy</i>	<i>Masturbation</i>	<i>Orgasm (coming)</i>

Note: This research project is an attempt to find out more about how men are coping in the programme. You are guaranteed that the personal information you provide will remain confidential. If you have any concerns regarding this please ask to speak with Nicola Scott or Steve Hudson.

SEXUAL FANTASY

A sexual thought or idea that occurs inside of you (e.g. a thought that just popped into your mind, or when you find yourself daydreaming.)

SEXUAL URGES

A sexual thought or an urge you felt, triggered by something outside of you, (e.g. looking at T.V. or magazines, hearing or smelling something, seeking out people to be sexual with).

MASTURBATION

Stimulating or rubbing your penis for the purpose of sexual pleasure.

ORGASM

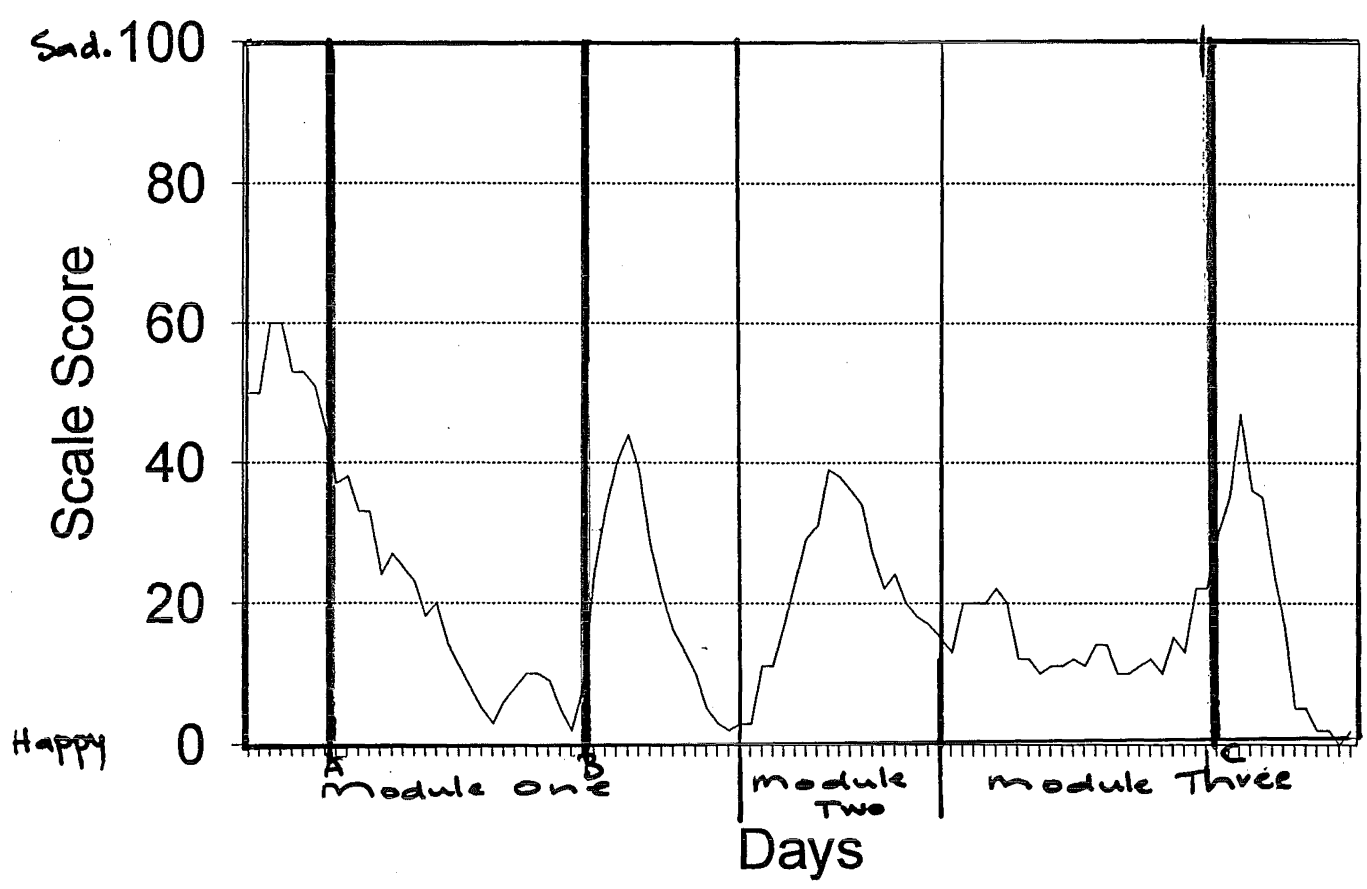
Ejaculating, "coming," "shooting your bolt," etc. (Usually orgasm follows masturbation - tick both boxes.)

Appendix Seven.

Subject 1.

Happy 0 - Sad 100

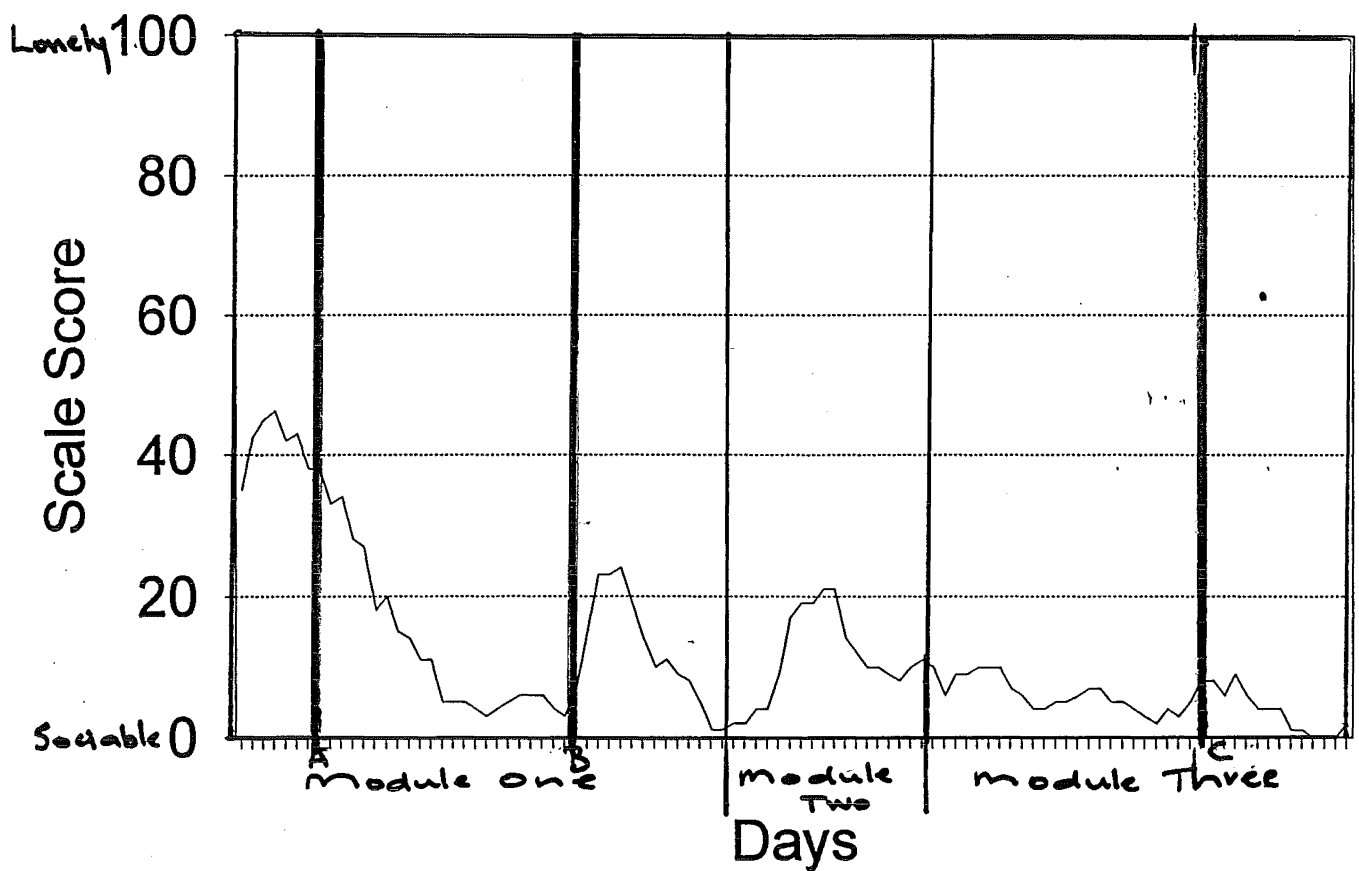
Subject 1 Scale 1



- A - Cognitive Distortions
- B - Cognitive Distortions.
- C - Victim Impact / Empathy.

Subject 1.

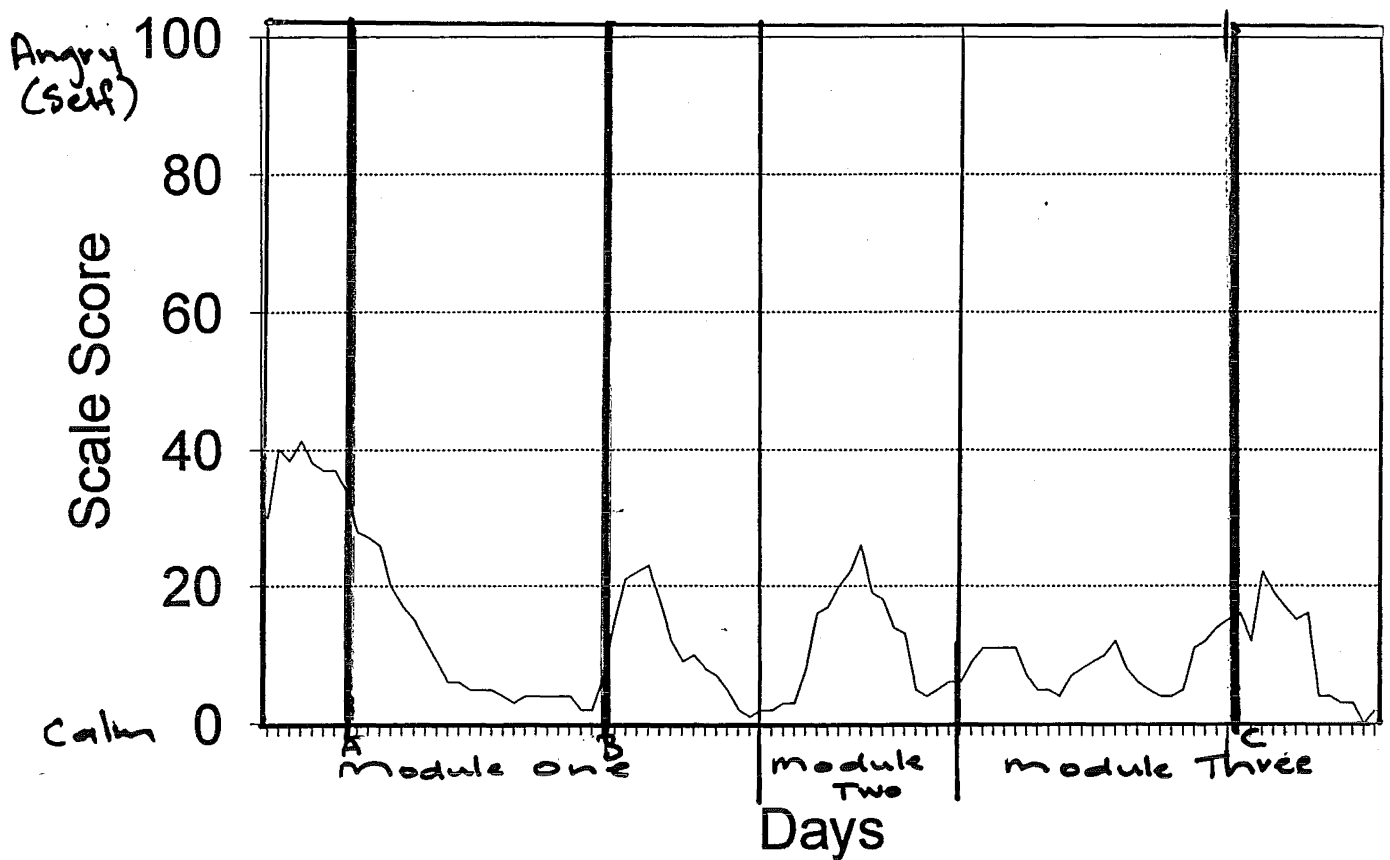
Subject 1 Scale 2



- A - Cognitive Distortions
- B - Cognitive Distortions.
- C - Victim Impact / Empathy.

Subject 1.

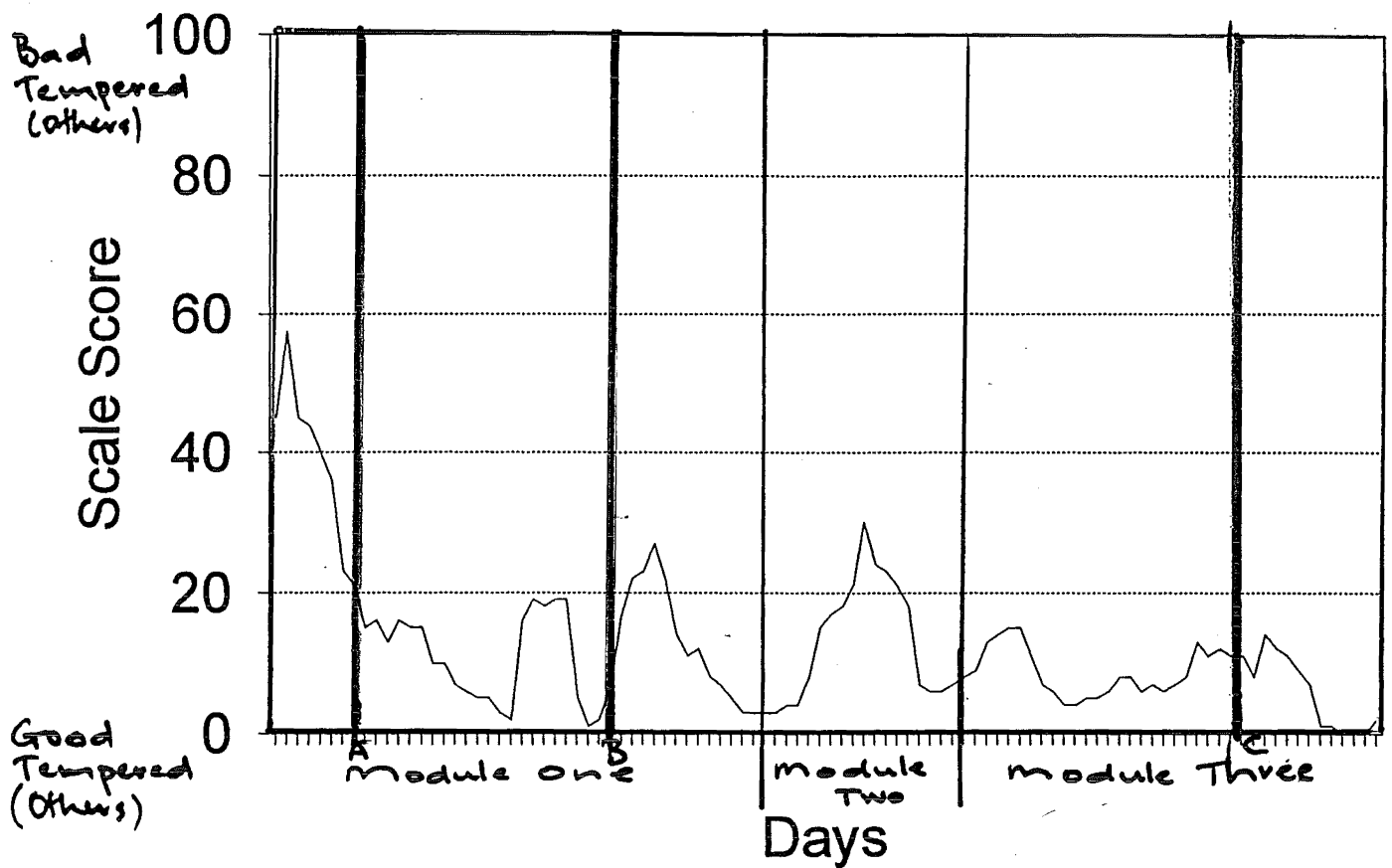
Subject 1 Scale 3



- A - Cognitive Distortions
- B - Cognitive Distortions.
- C - Victim Impact / Empathy.

Subject 1.

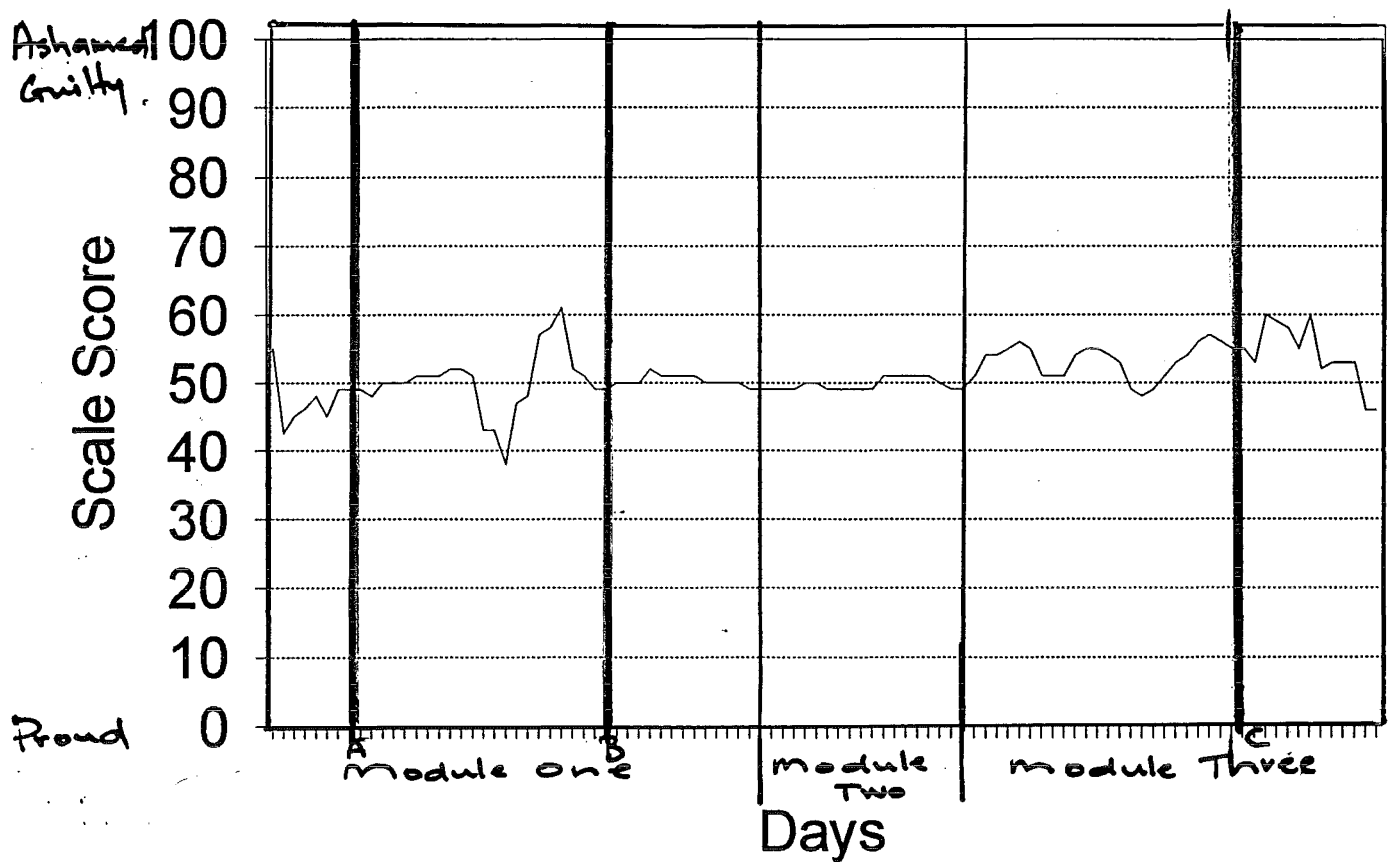
Subject 1 Scale 4



- A - Cognitive Distortions
- B - Cognitive Distortions.
- C - Victim Impact / Empathy.

Subject 1.

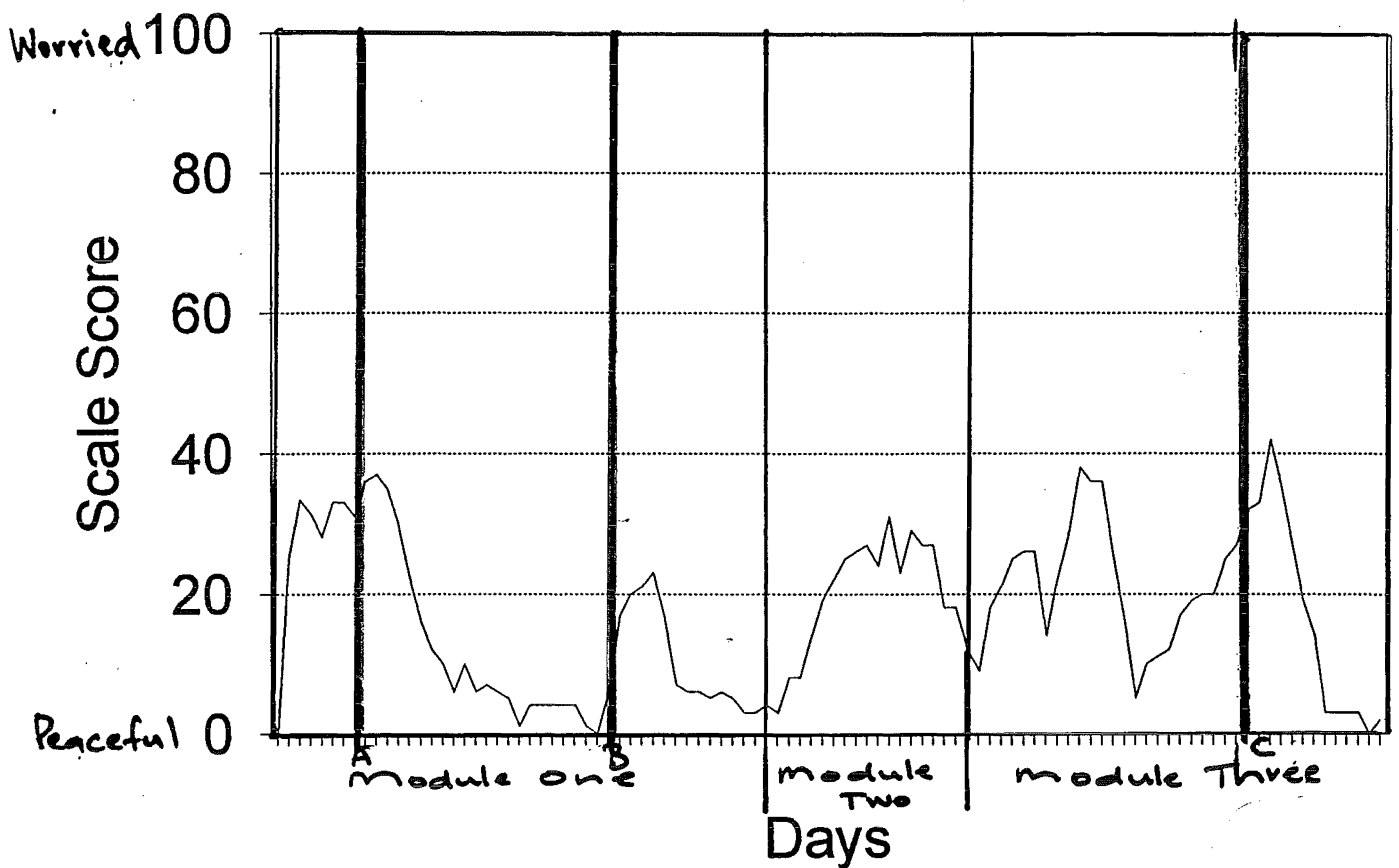
Subject 1 Scale 5



- A - Cognitive Distortions
- B - Cognitive Distortions.
- C - Victim Impact / Empathy.

Subject 1.

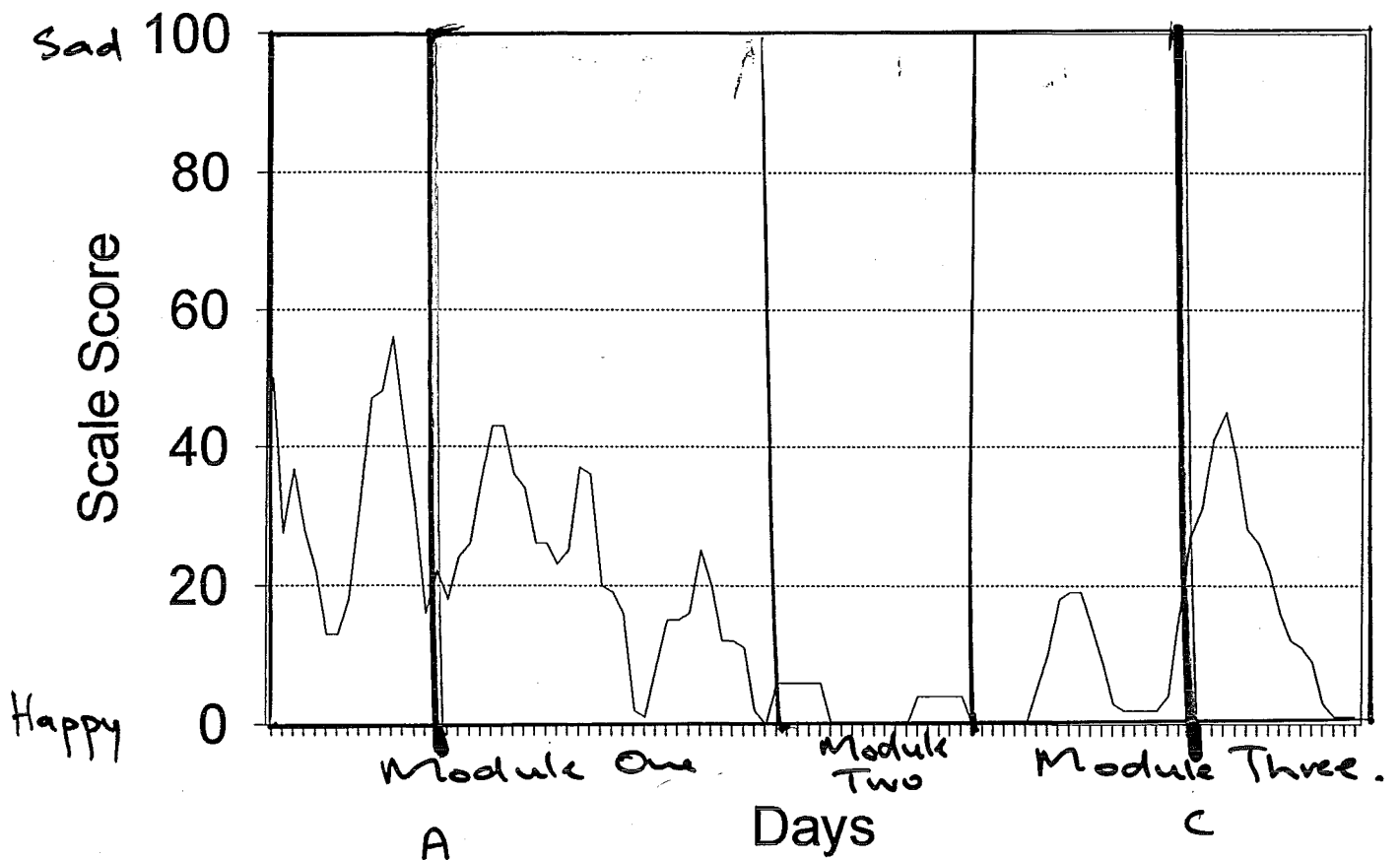
Subject 1 Scale 6



A - Cognitive Distortions
B - Cognitive Distortions.
C - Victim Impact / Empathy.

Subject 2.

Subject 2 Scale 1

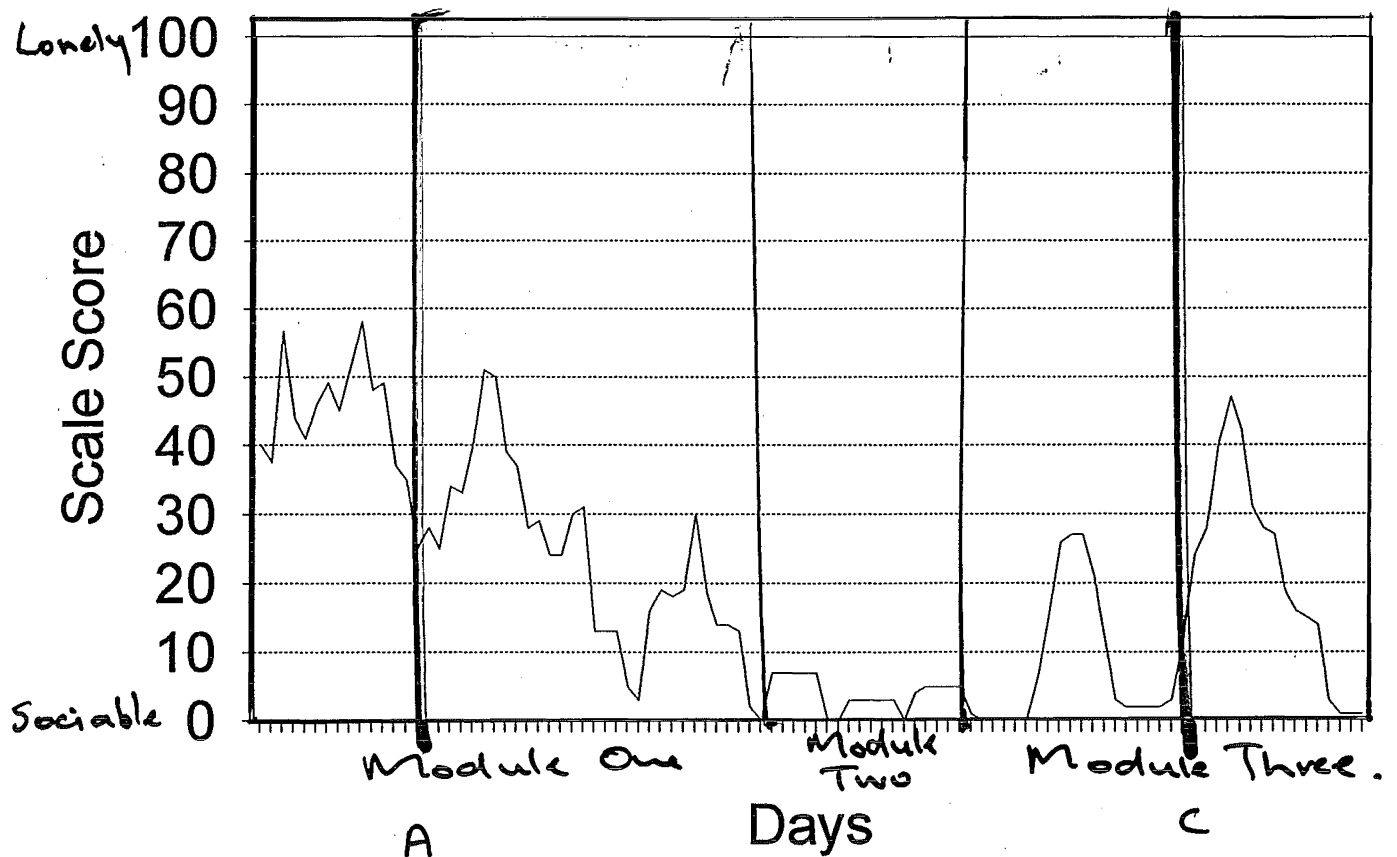


Hotseat

- A Cognitive Distortions Offense Cycle 1
- B No Recording.
- C Victim Impact Empath.

Subject 2.

Subject 2 Scale 2

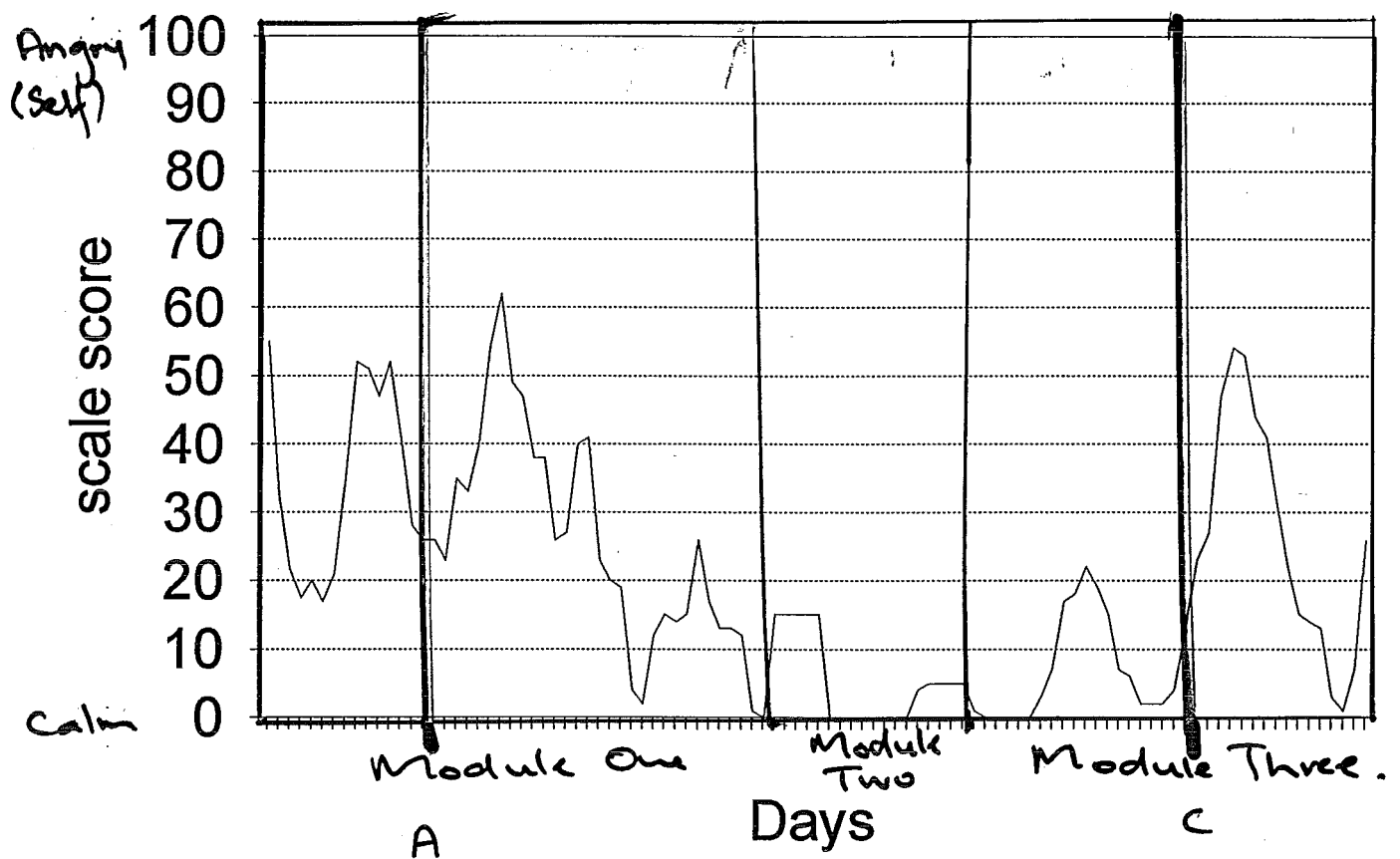


Hotseat

- A Cognitive Distortions Offense Cycle 1
- B No Recording.
- C Victim Impact Empath.

Subject 2.

Subject 2 Scale 3

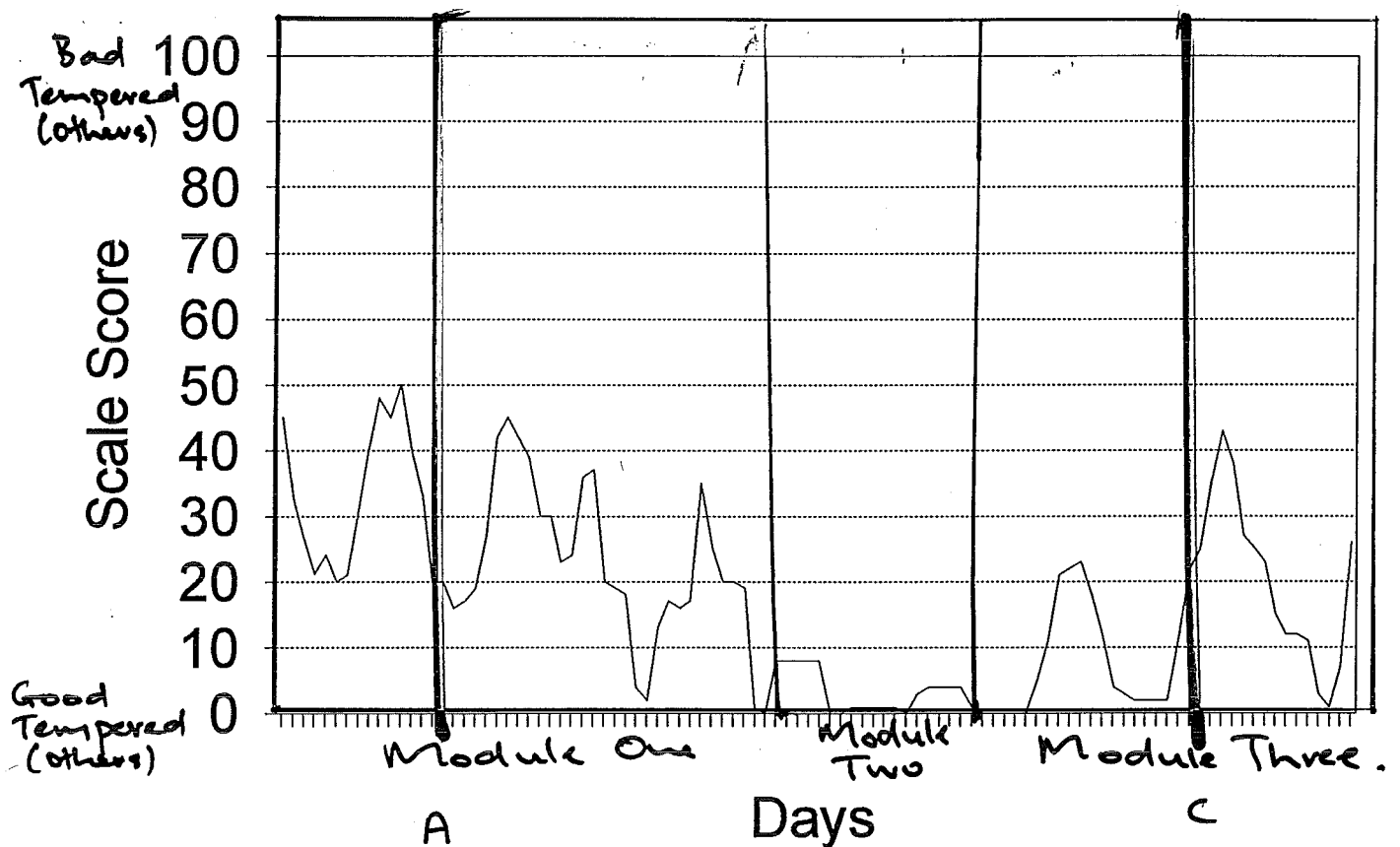


Hotseat

- A Cognitive Distortions Offense Cycle 1
- B No Recording.
- C Victim Impact Empath.

Subject 2.

Subject 2 Scale 4

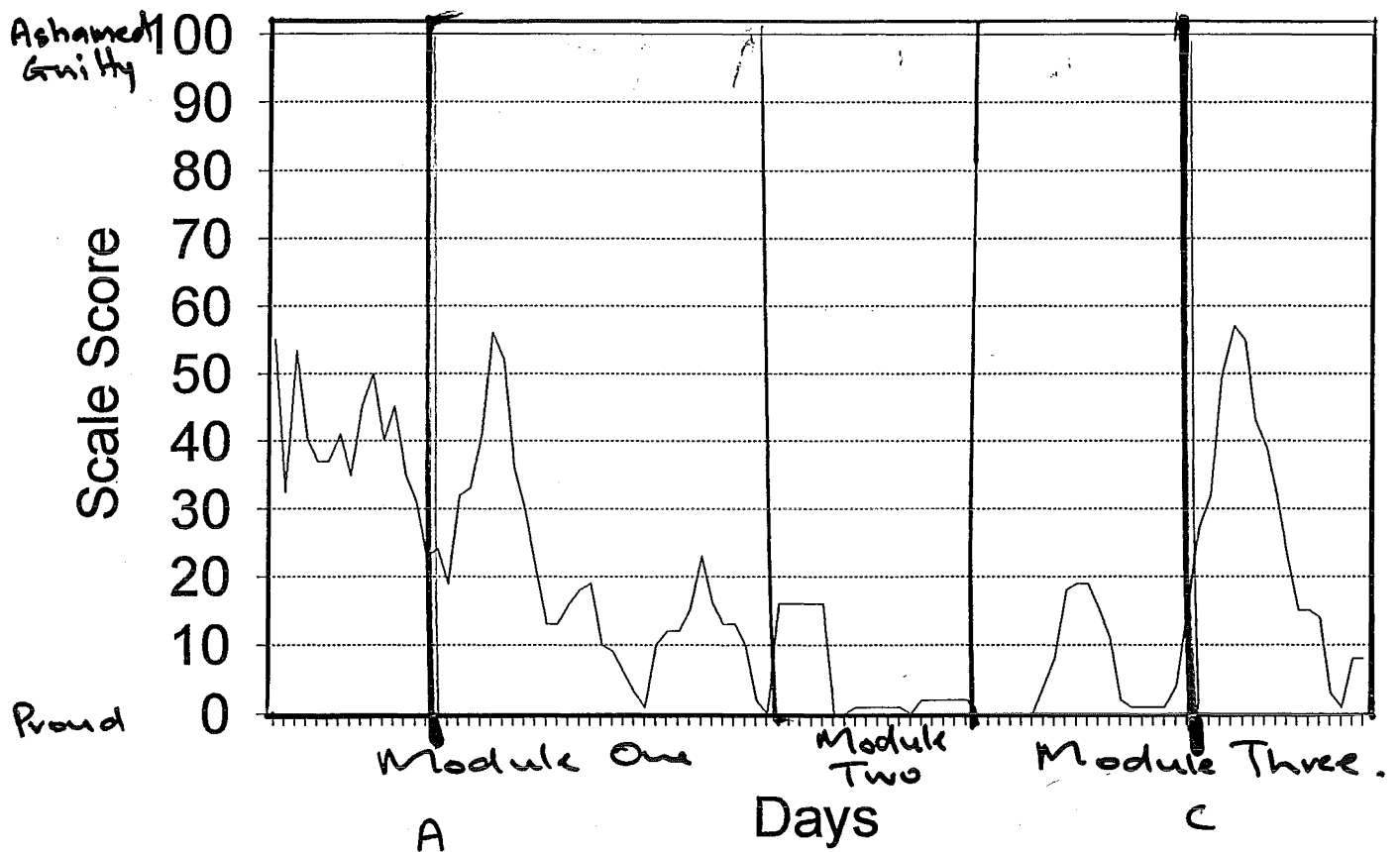


Hotseat

A Cognitive Distortions Offence Cycle 1
B No Recording.
C Victim Impact Empath.

Subject 2.

Subject 2 Scale 5

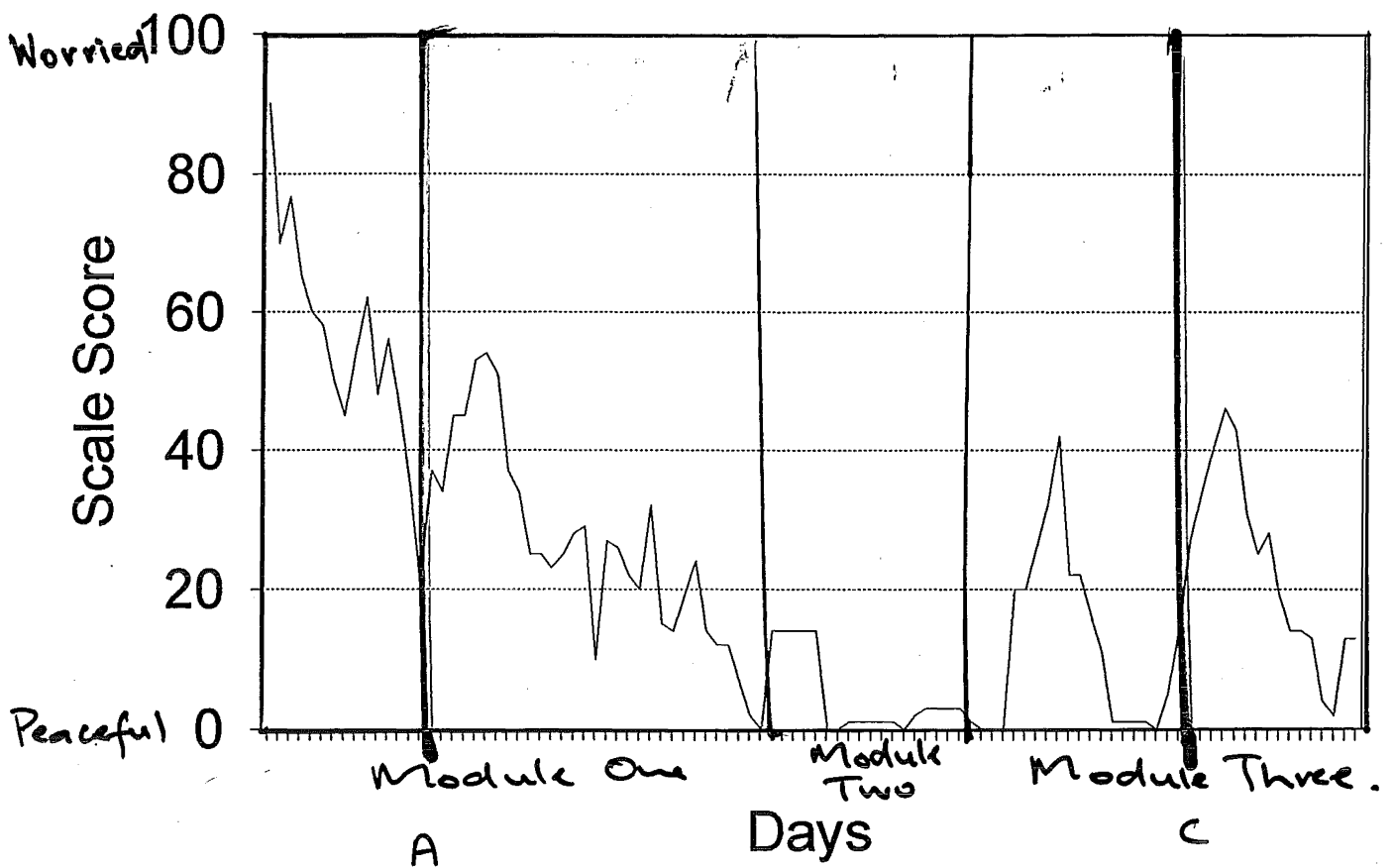


Hotseat

- A Cognitive Distortions Offense Cycle 1
- B No Recording.
- C Victim Impact Empath.

Subject 2.

Subject 2 Scale 6

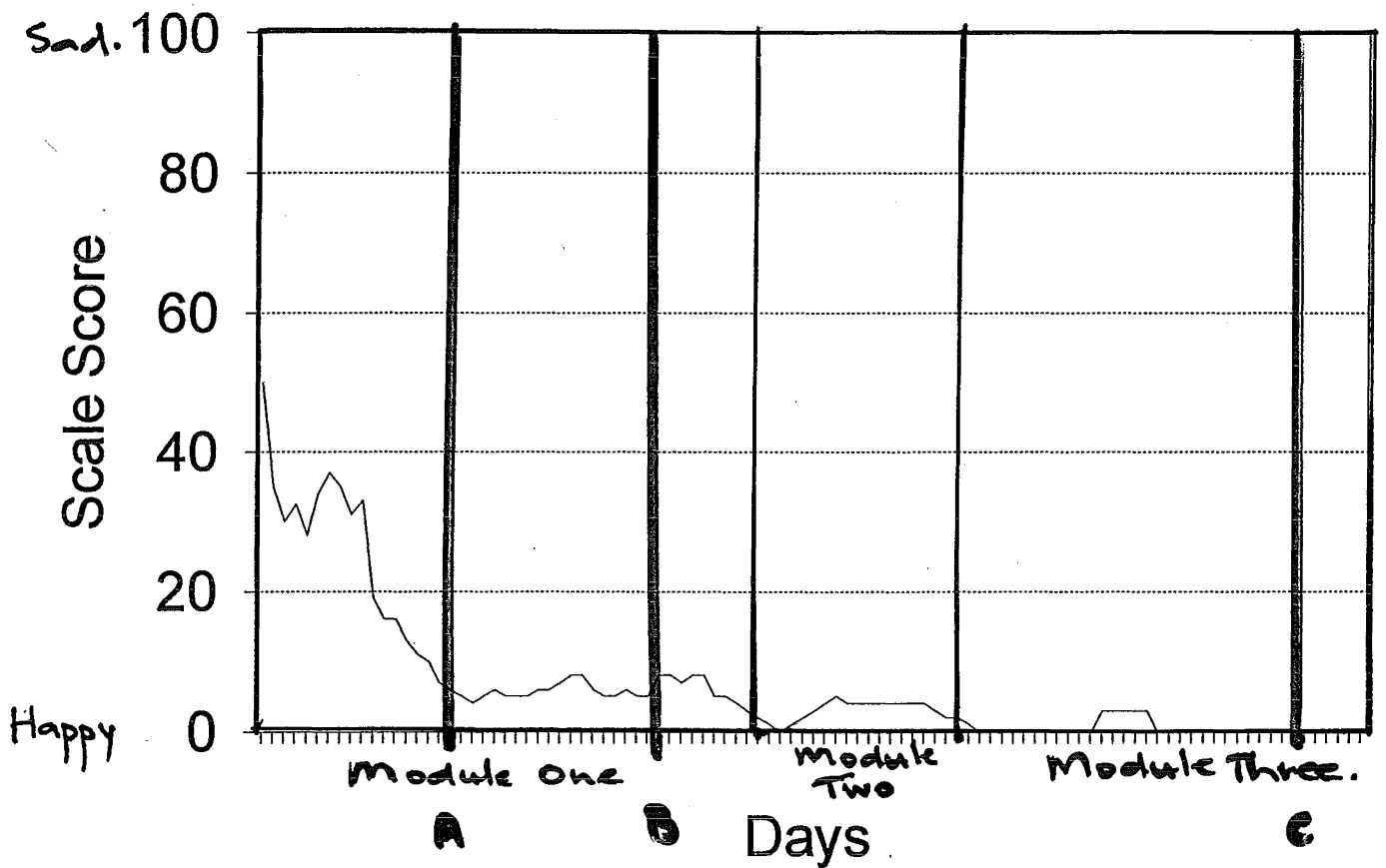


Hotseat:

- A Cognitive Distortions Offense Cycle 1
- B No Recording.
- C Victim Impact Empath.

Subject 3

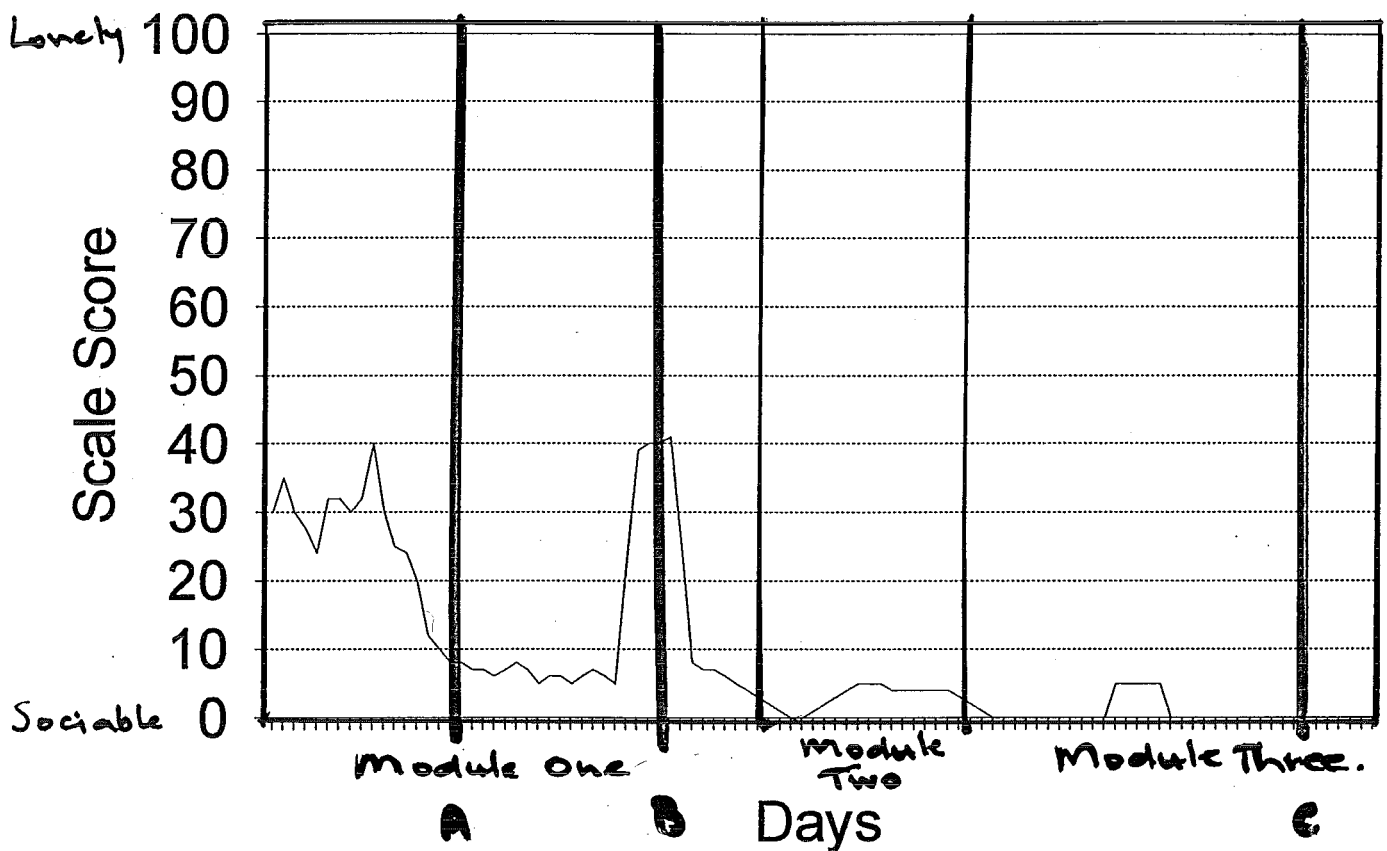
Subject 3 Scale 1



- A - Cognitive Distortions offence Cycle 1
- B - Cognitive Distortions offence Cycle 2
- C - Victim Impact/Empathy ~~1~~

Subject 3

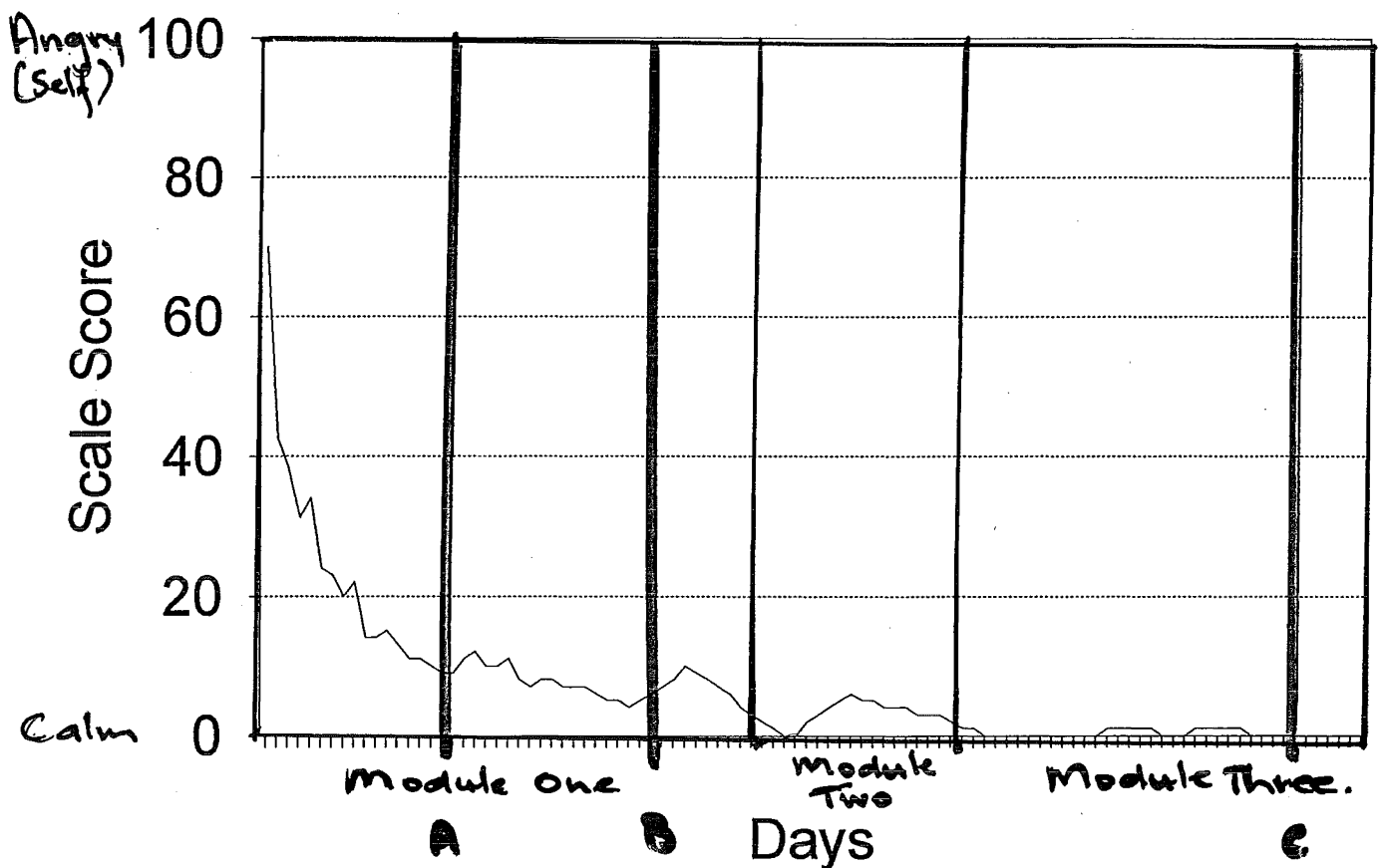
Subject 3 Scale 2



A - Cognitive Distortions offence Cycle 1
B - Cognitive Distortions offence Cycle 2
C - Victim Impact/Empathy ~~Module~~

Subject 3

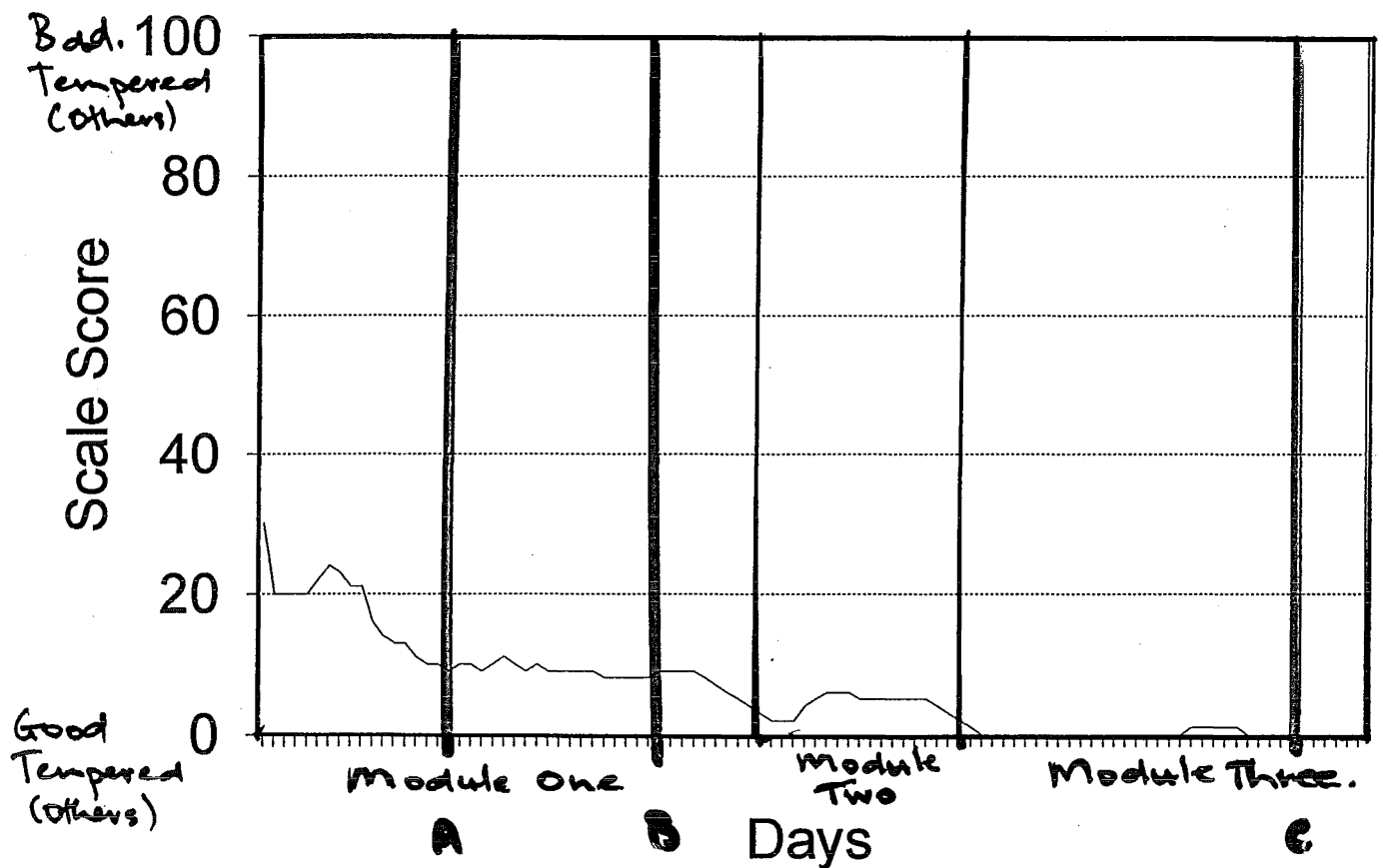
Subject 3 Scale 3



- A - Cognitive Distortions offence Cycle 1
B - Cognitive Distortions offence Cycle 2
C - Victim Impact/Empathy ~~1~~

Subject 3

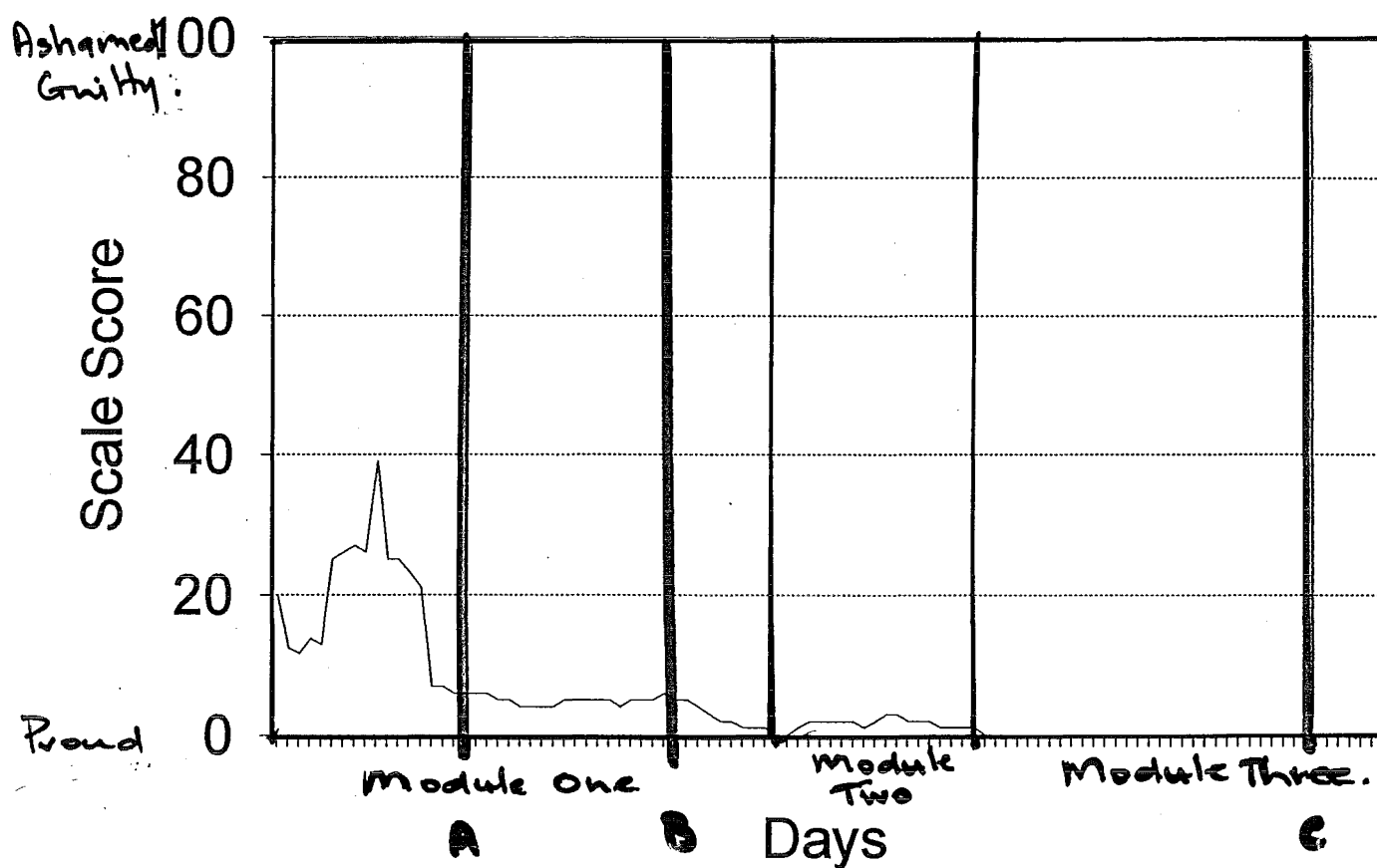
Subject 3 Scale 4



A - Cognitive Distortions offence Cycle 1
B - Cognitive Distortions offence Cycle 2
C - Victim Impact/Empathy ~~1~~

Subject 3

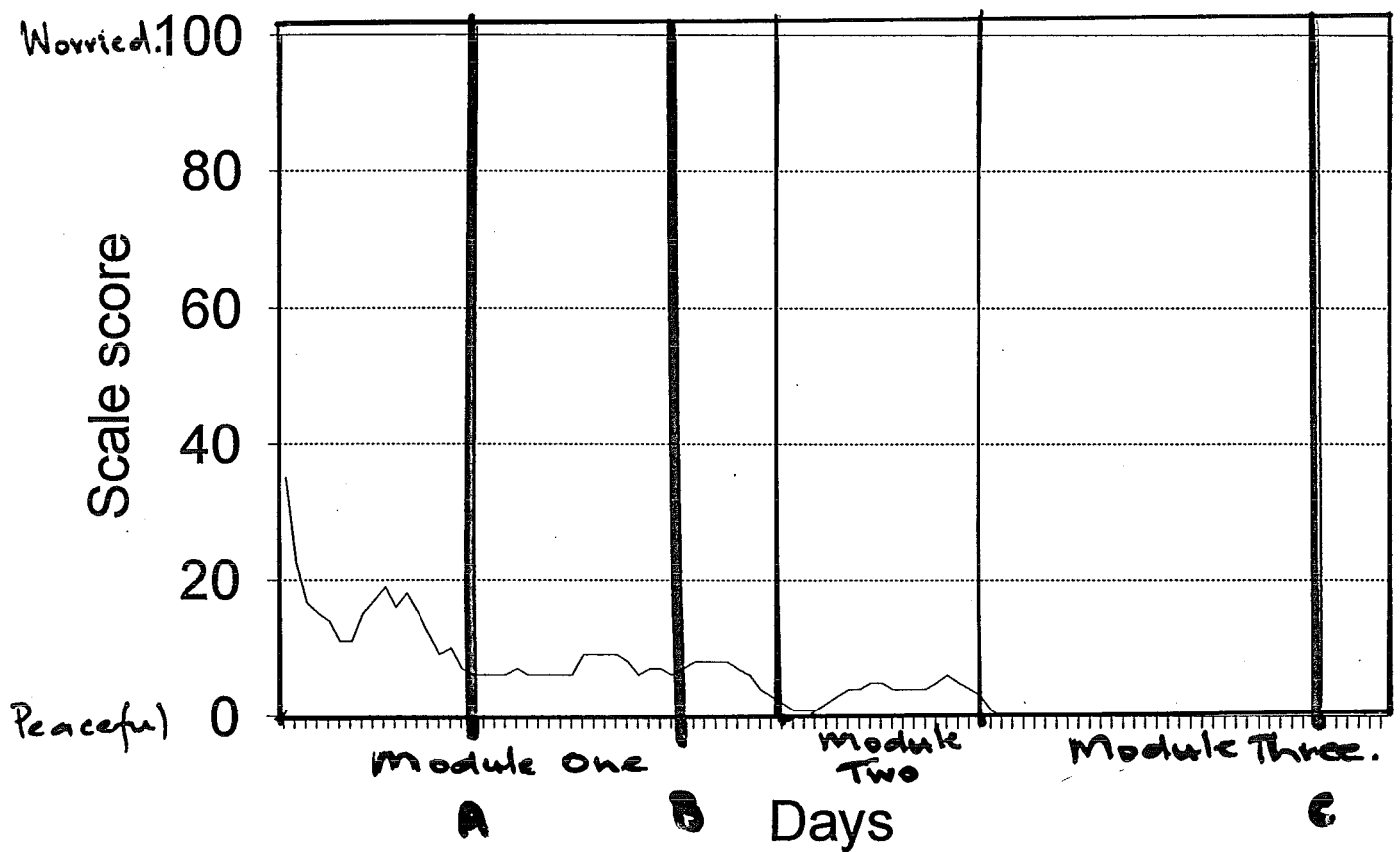
Subject 3 Scale 5



A - Cognitive Distortions offence Cycle 1
B - Cognitive Distortions offence Cycle 2
C - Victim Impact/Empathy ~~Module~~

Subject 3

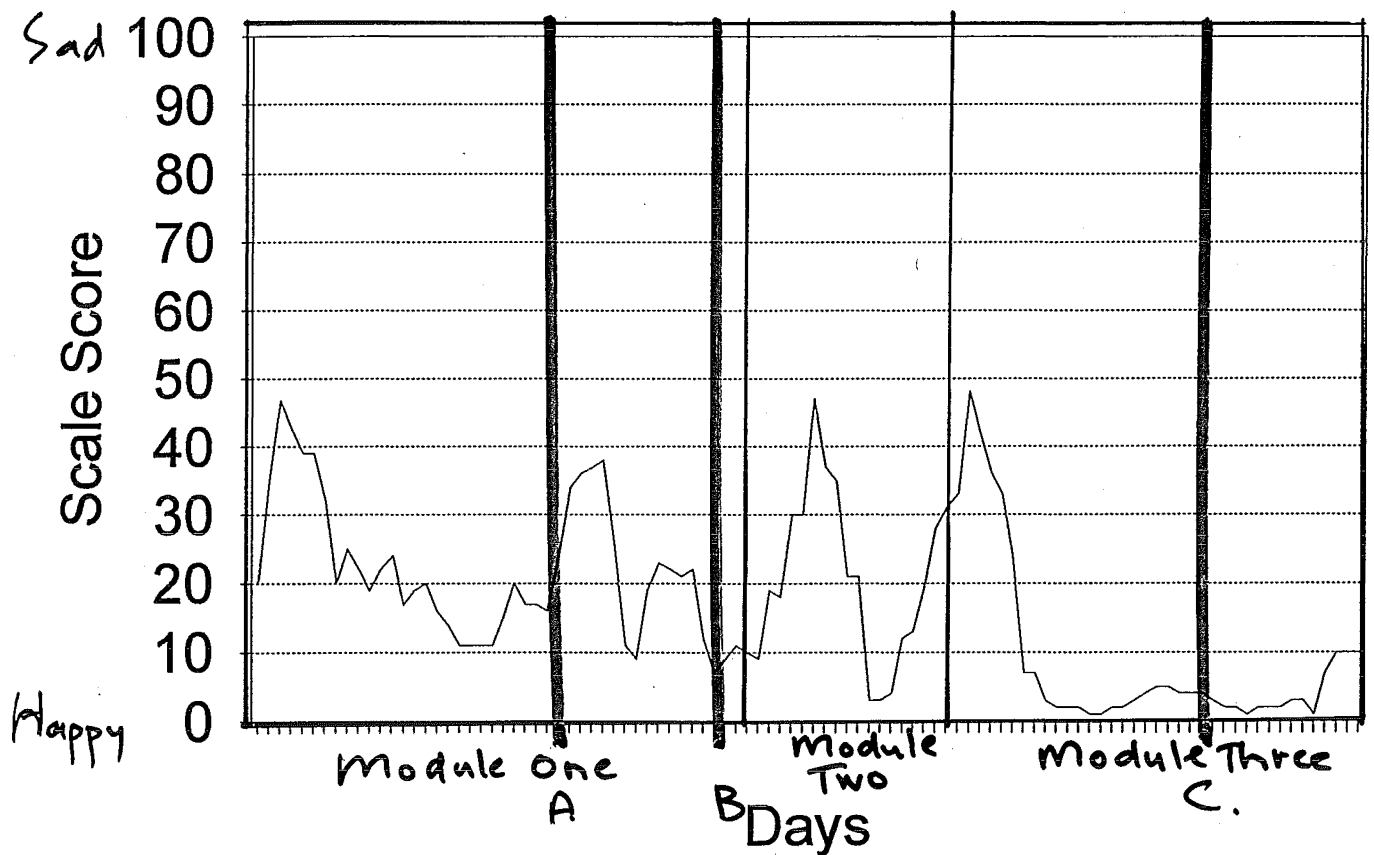
Subject 3 Scale 6



A - Cognitive Distortions offence Cycle 1
B - Cognitive Distortions offence Cycle 2
C - Victim Impact/Empathy ~~1~~

Subject 4

Sub 4 Scale 1

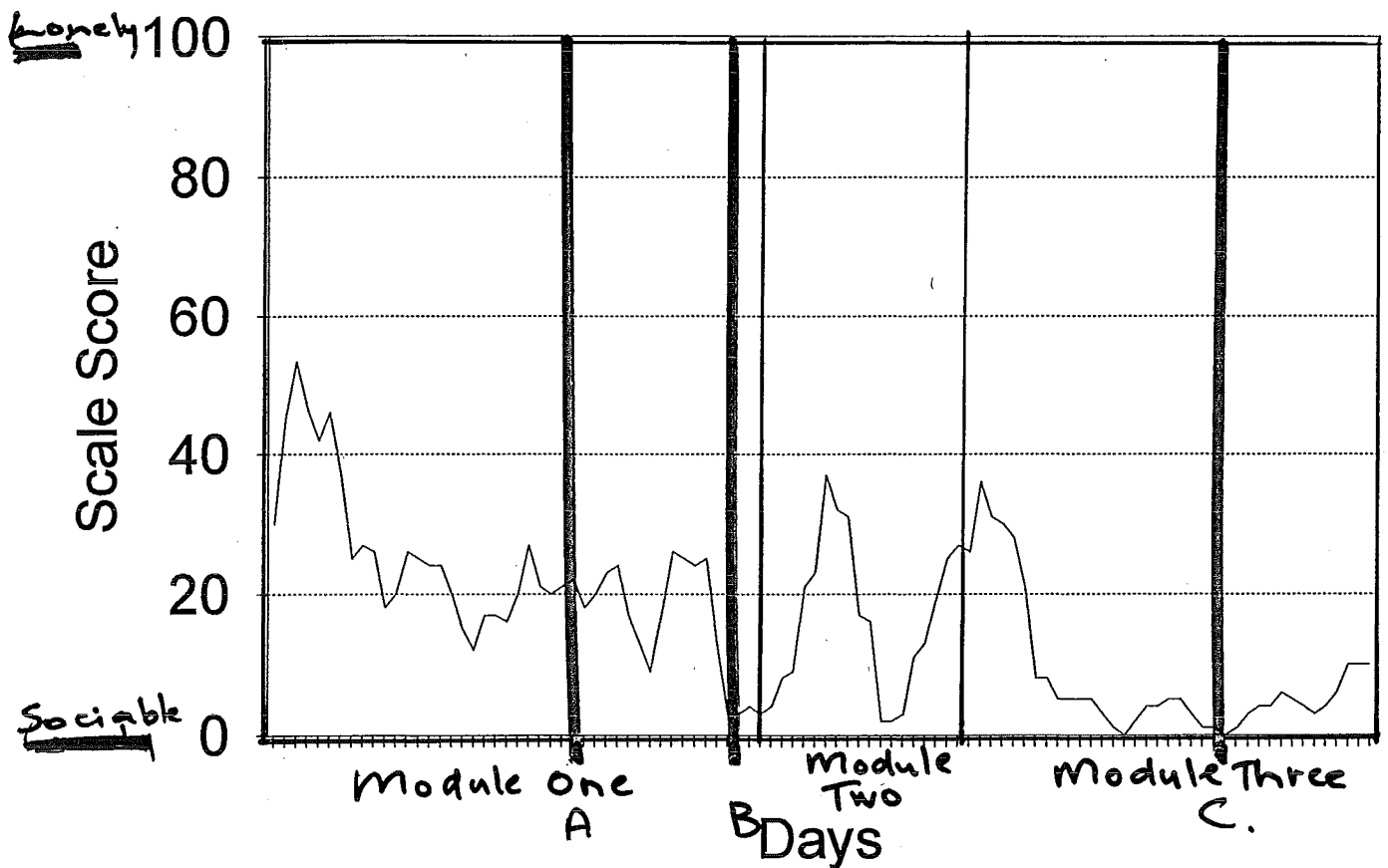


"Hotseat"

- A - Cognitive Distortions - Offence Cycle 1
- B - Cognitive Distortions - Offence Cycle 2
- C - Victim Impact / Empathy

Subject 4

Subject 4 Scale 2



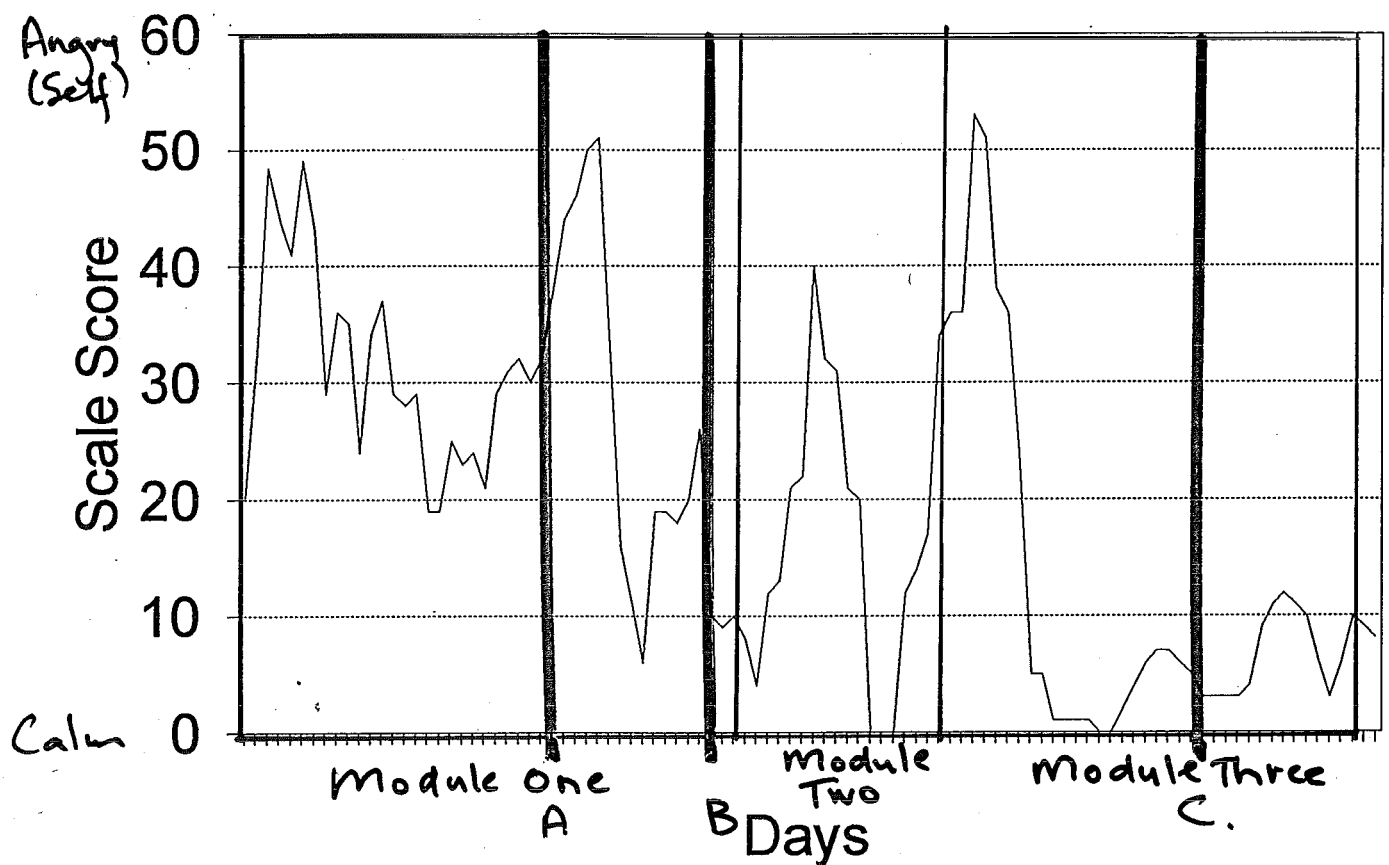
"Hotsent"

- A - Cognitive Distortions - Offence Cycle 1
- B - Cognitive Distortions - Offence Cycle 2
- C - Victim Impact / Empathy

Note Not Graduated to 100.

Subject 4

Subject 4 Scale 3

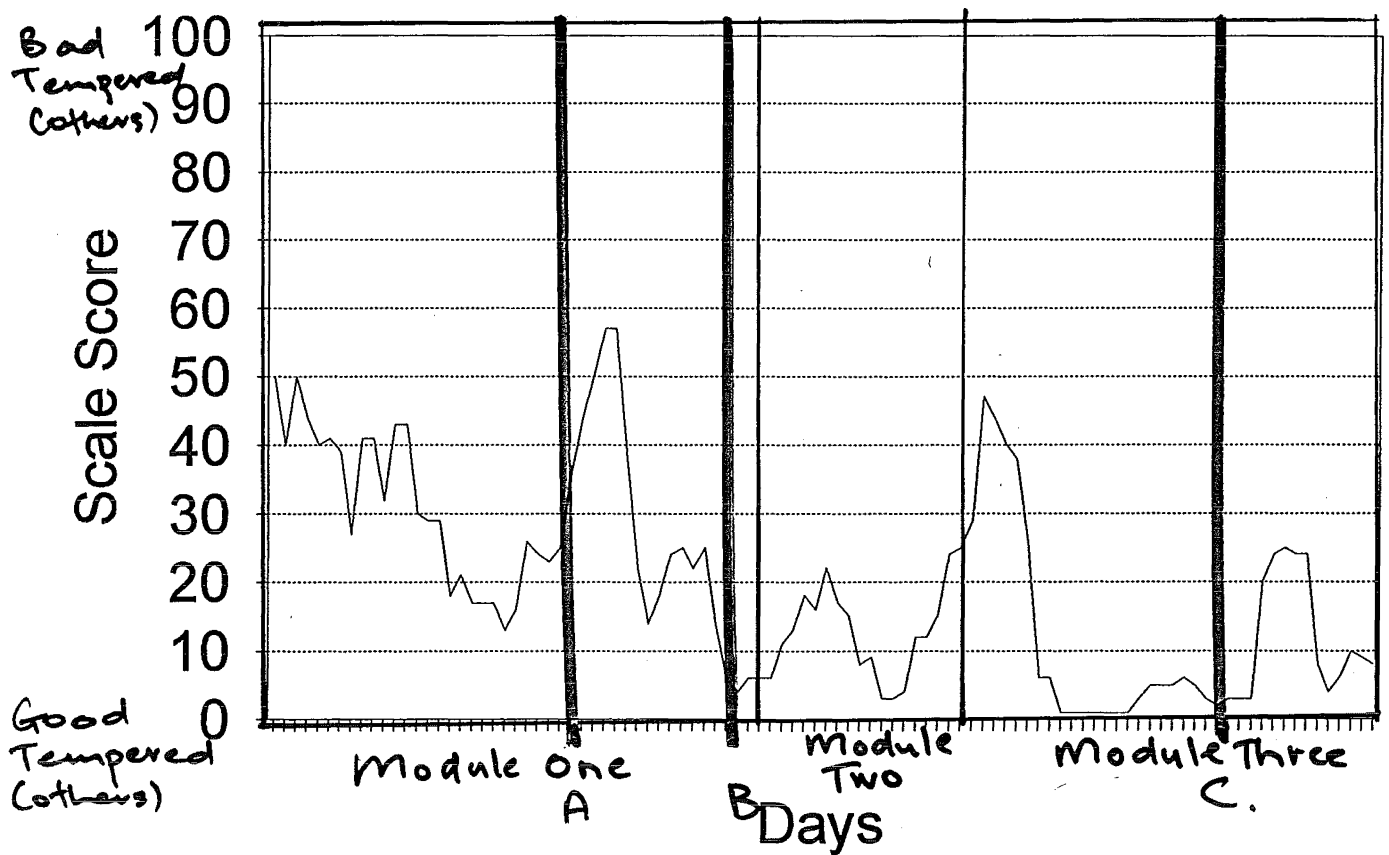


"Hotseat"

- A - Cognitive Distortions - Offence Cycle 1
- B - Cognitive Distortions - Offence Cycle 2
- C - Victim Impact / Empathy

Subject 4

Subject 4 Scale 4

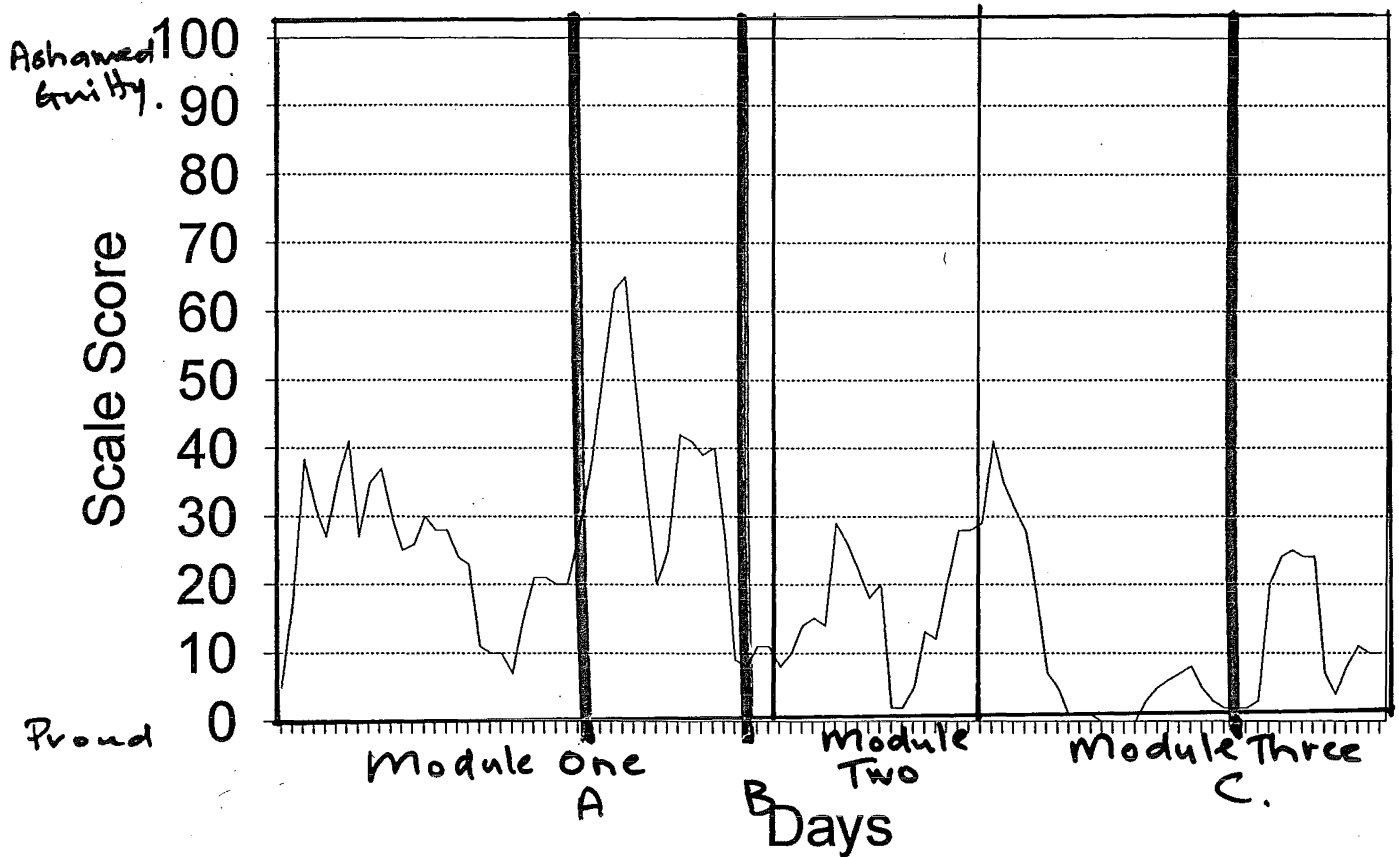


"Hotseat"

- A - Cognitive Distortions - Offence Cycle 1
- B - Cognitive Distortions - Offence Cycle 2
- C - Victim Impact / Empathy

Subject 4

Sub 4 Scale 5

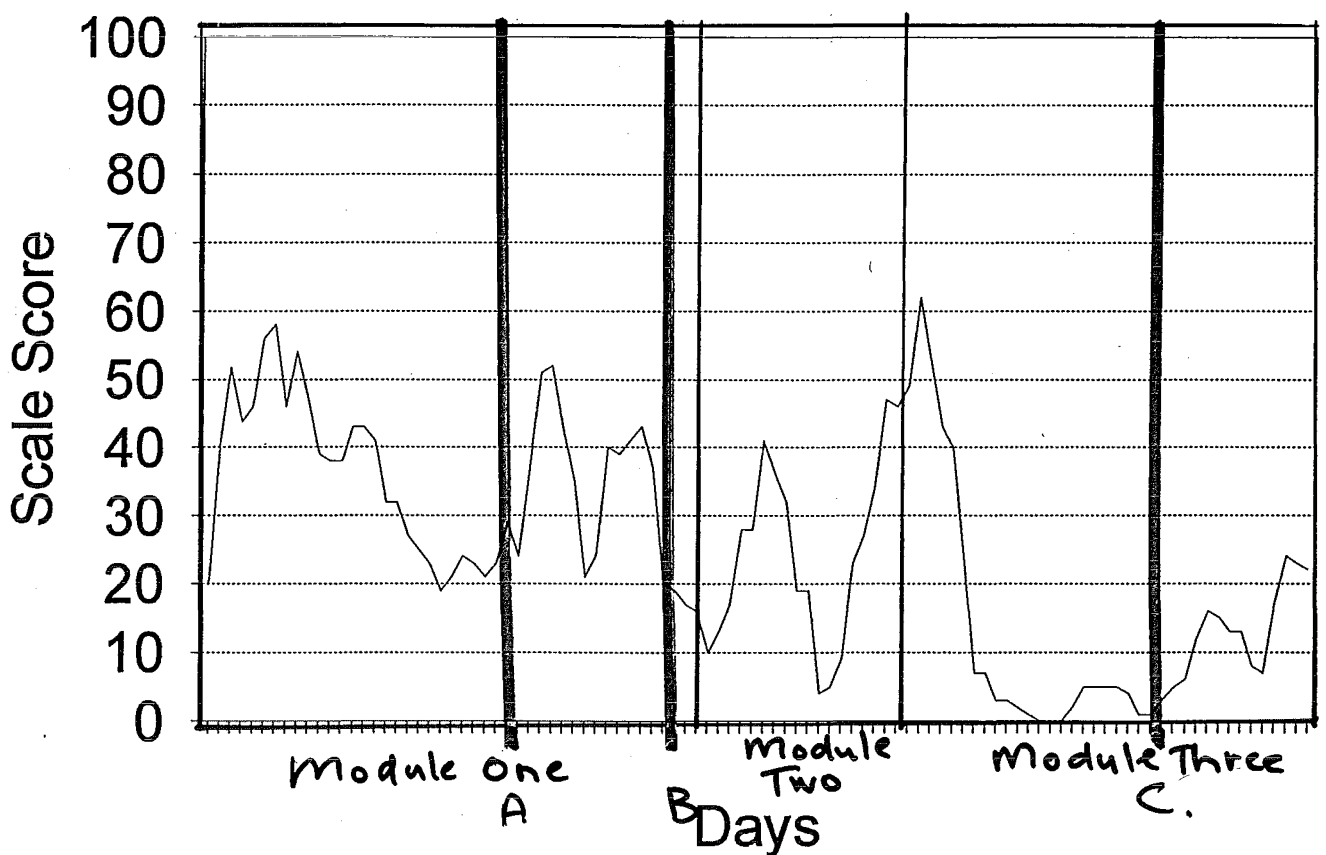


"Hotseat"

- A - Cognitive Distortions - Offense Cycle 1
- B - Cognitive Distortions - Offense Cycle 2
- C - Victim Impact (Empathy)

Subject 4

Sub 4 Scale 6

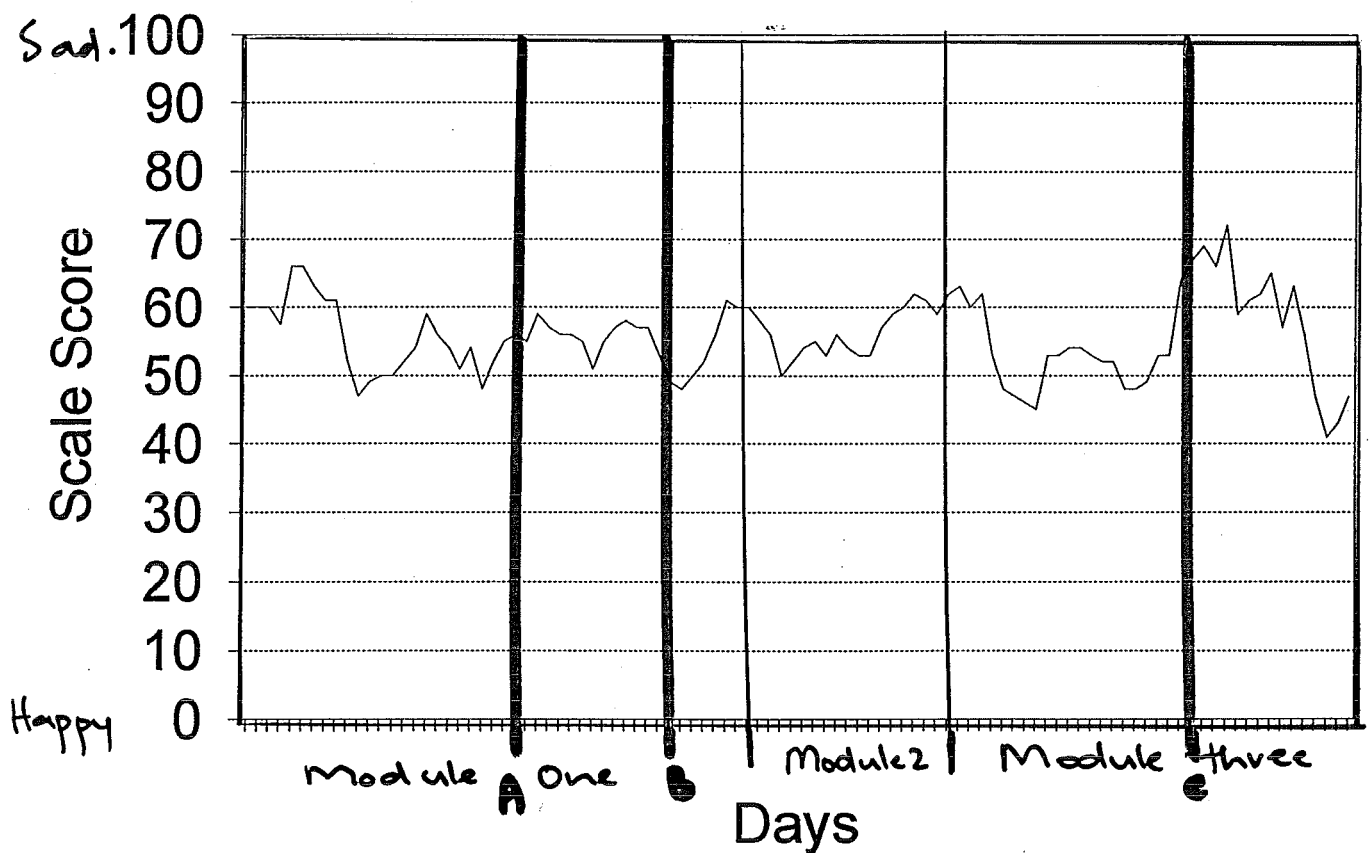


"Hotseat"

- A - Cognitive Distortions - Offence Cycle 1
- B - Cognitive Distortions - Offence Cycle 2
- C - Victim Impact / Empathy

Subject 5

Sub 5 Scale 1

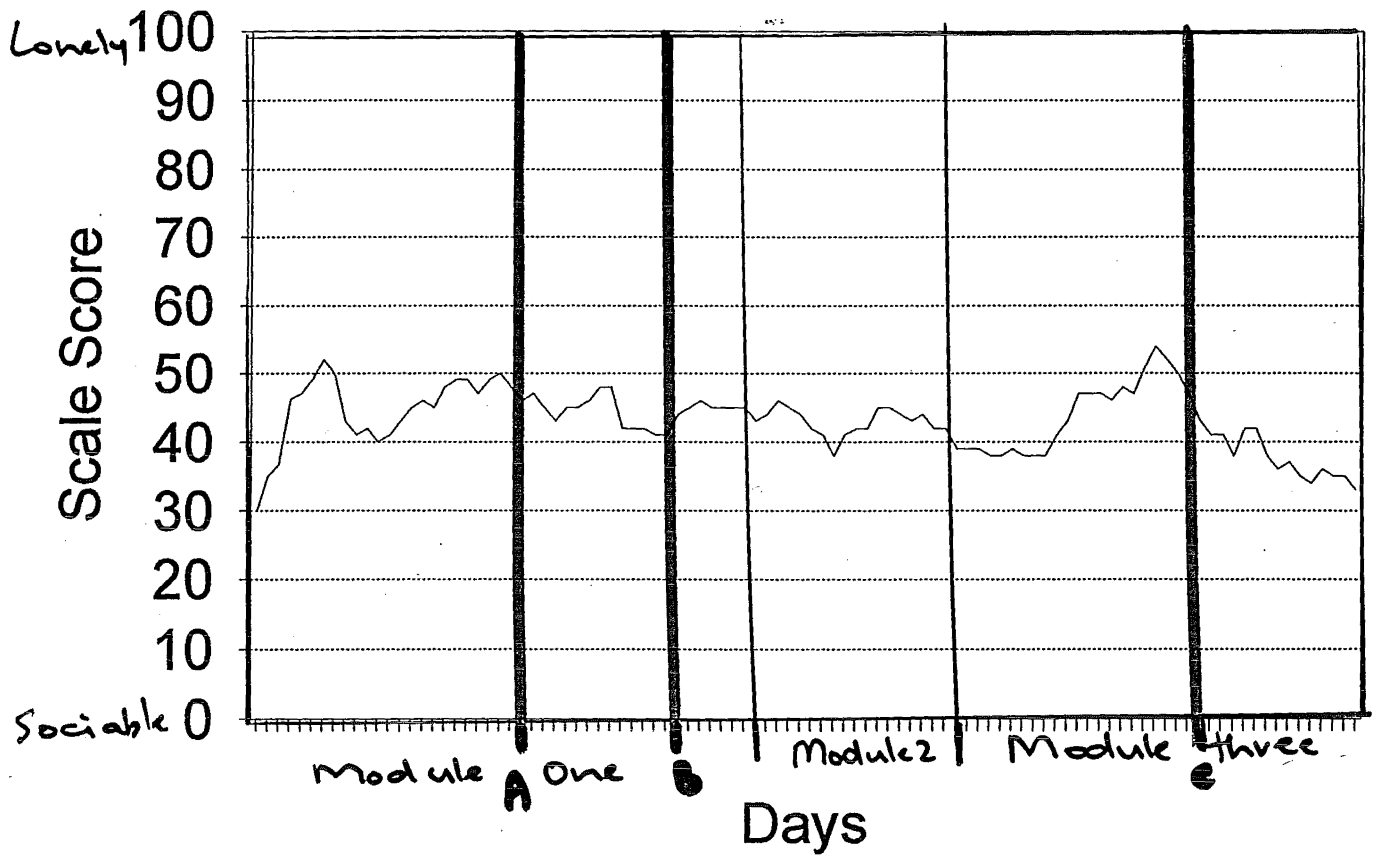


"Hotseat"

- A - Cognitive Distortions offence Cycle 1
- B - Cognitive Distortions offence Cycle 2
- C - Victim Impact / Empathy

Subject 5

Sub 5 Scale 2

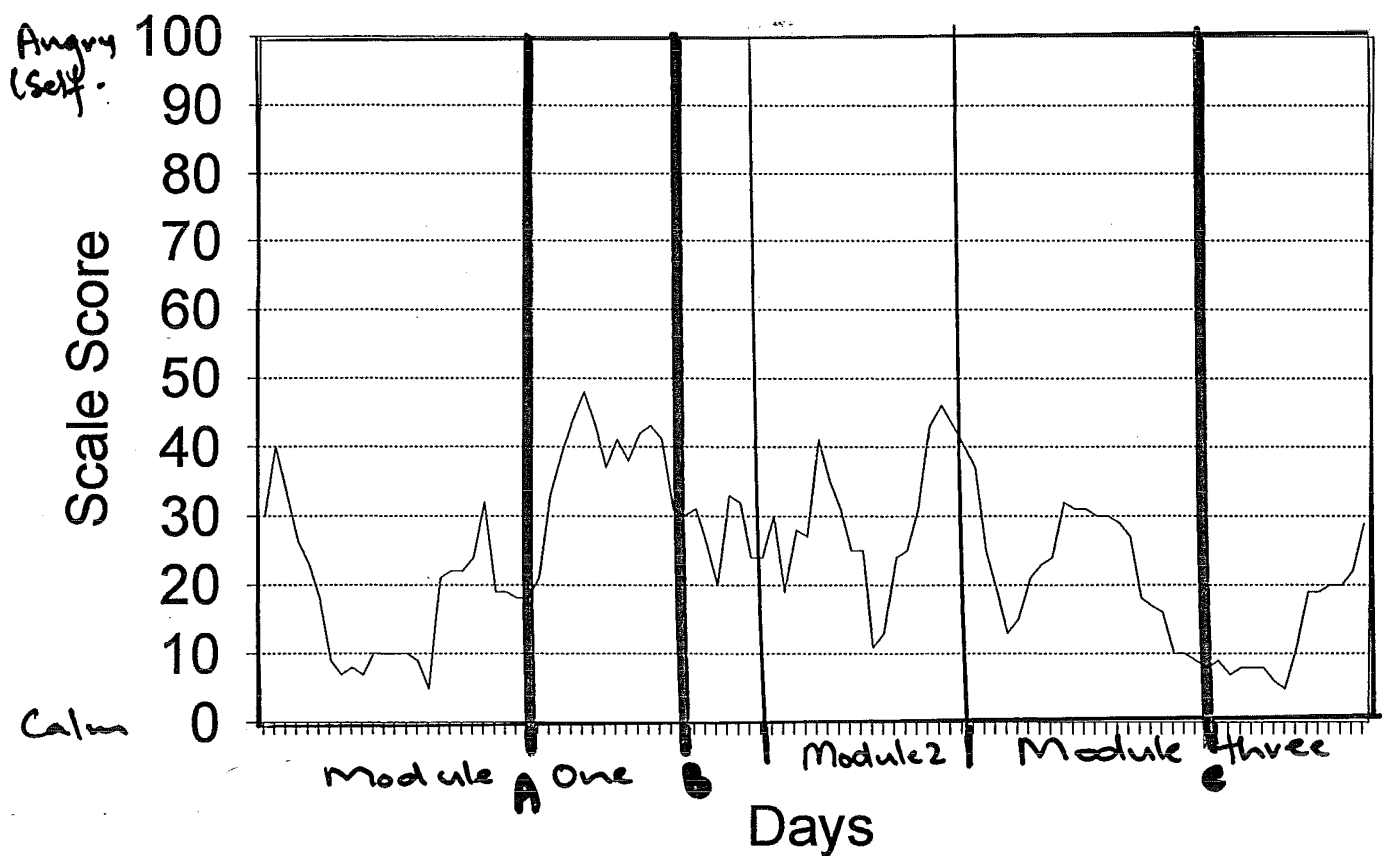


"Hotseat"

- A - Cognitive Distortions offence Cycle 1
- B - Cognitive Distortions offence Cycle 2
- C - Victim Impact / Empathy

Subject 5

Sub 5 Scale 3

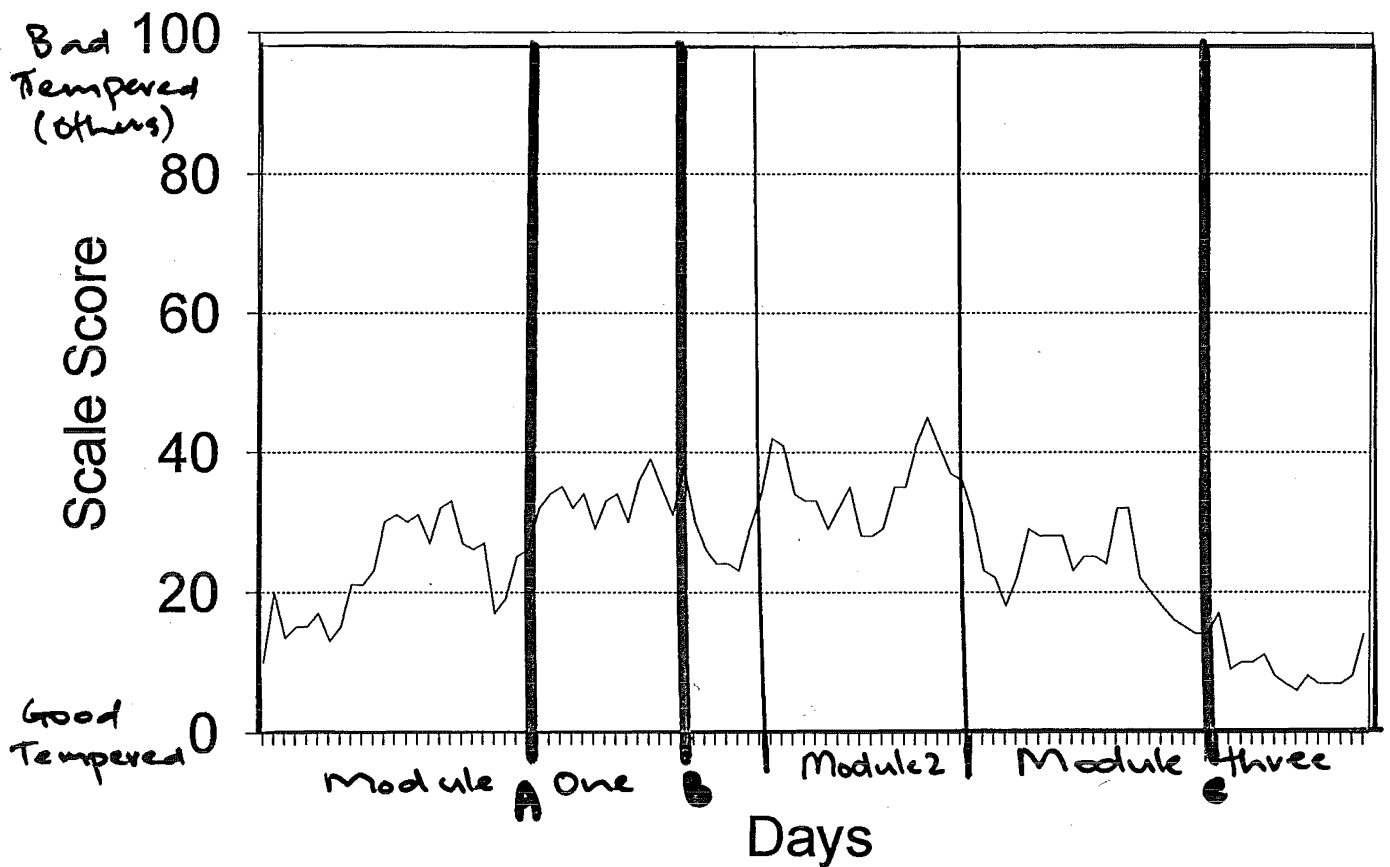


"Hotseat"

- A - Cognitive Distortions offence Cycle 1
- B - Cognitive Distortions offence Cycle 2
- C - Victim Impact / Empathy

Subject 5

Sub 5 Scale 4



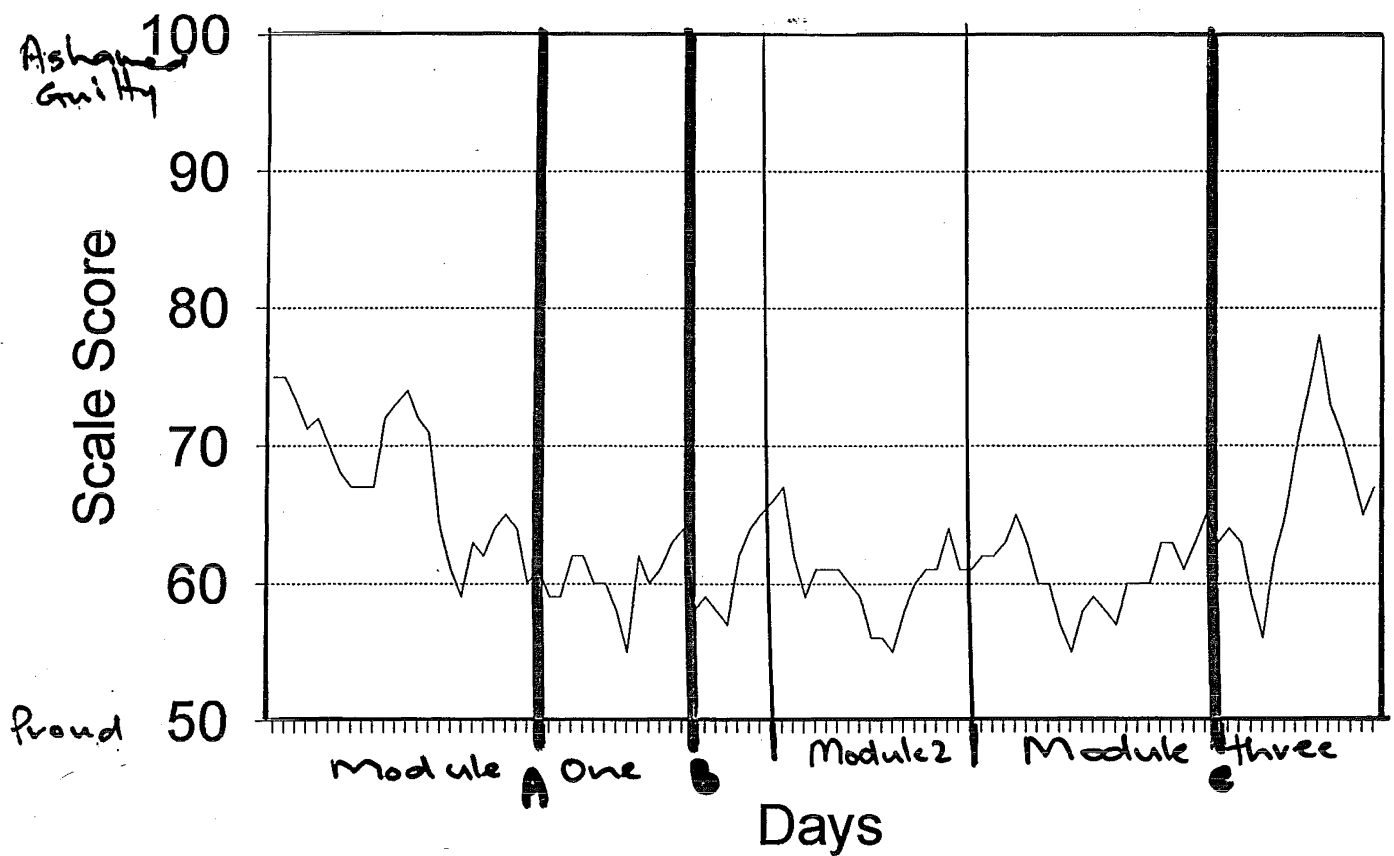
"Hotseat"

- A - Cognitive Distortions offence Cycle 1
- B - Cognitive Distortions offence Cycle 2
- C - Victim Impact / Empathy

Note Scale Not graduated from 0

Subject 5

Sub 5 Scale 5

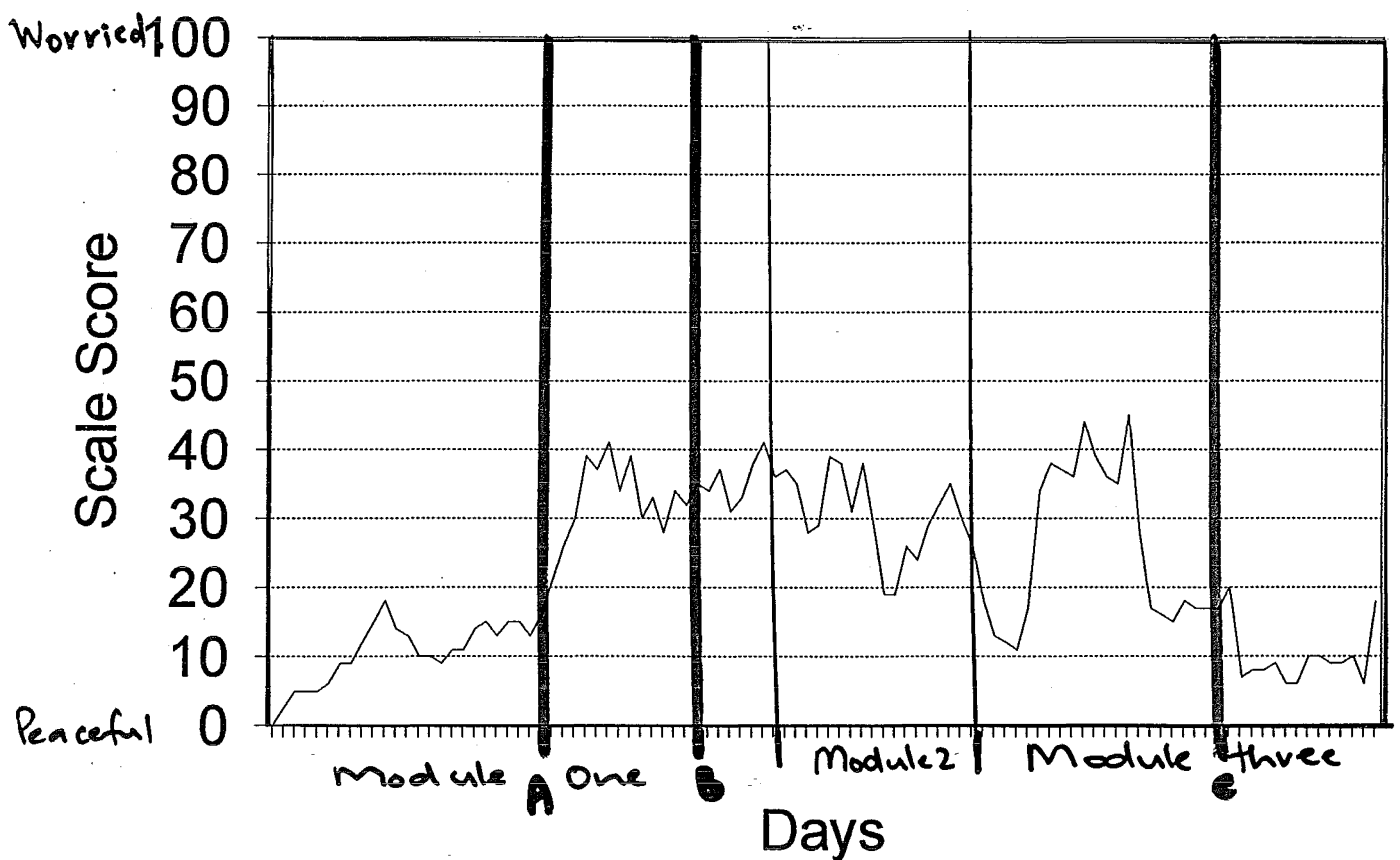


"Hotseat"

- A - Cognitive Distortions offence Cycle 1
- B - Cognitive Distortions offence Cycle 2
- C - Victim Impact / Empathy

Subject 5

Sub 5 Scale 6

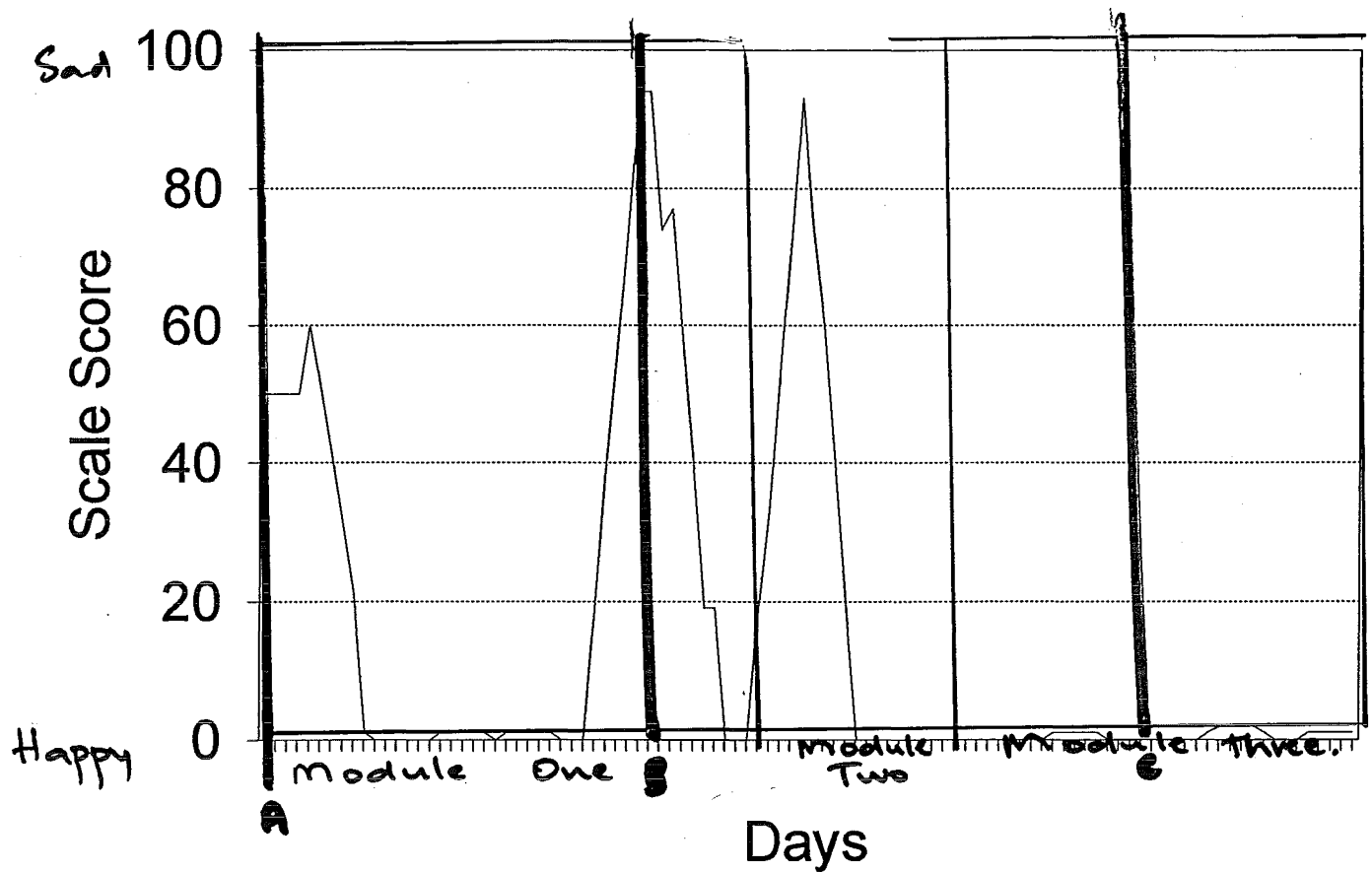


"Hotseat"

- A - Cognitive Distortions offence Cycle 1
- B - Cognitive Distortions offence Cycle 2
- C - Victim Impact / Empathy

Subject 6.

Subject 6 Scale 1

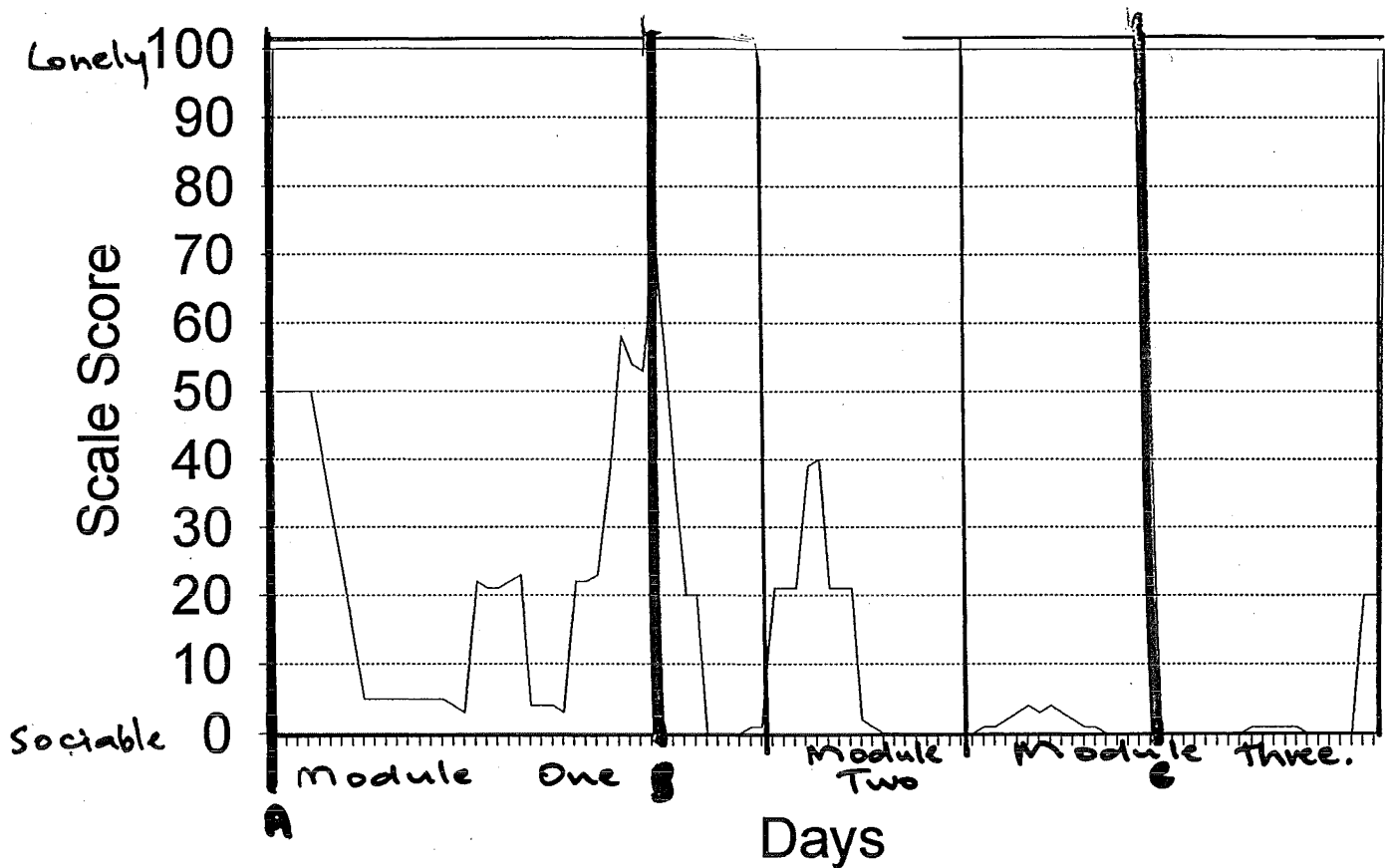


'Hotseat'

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact/Empathy.

Subject 6.

Sub 6 Scale 2

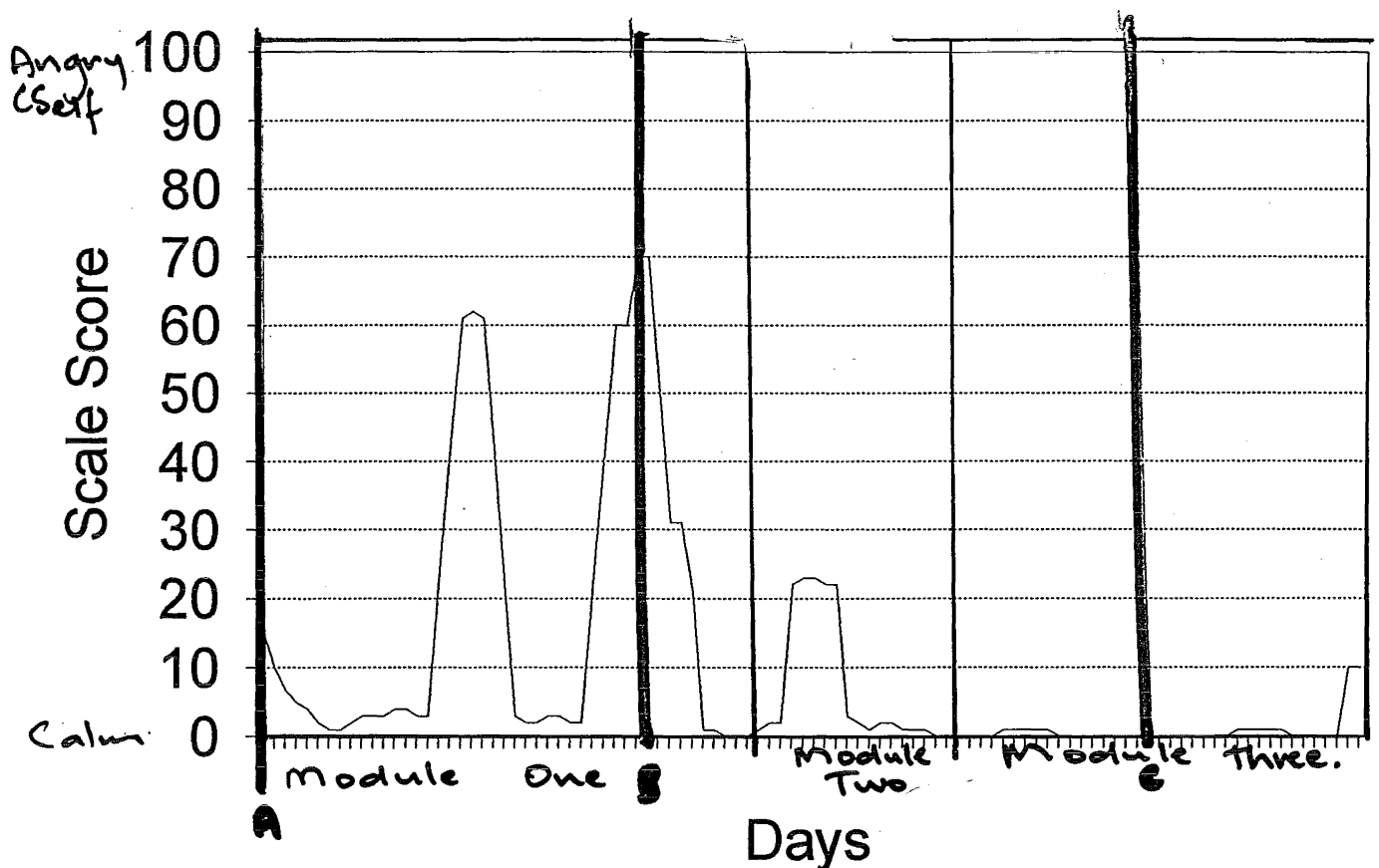


"Hotseat"

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact/Empathy.

Subject 6.

Sub 6 Scale 3

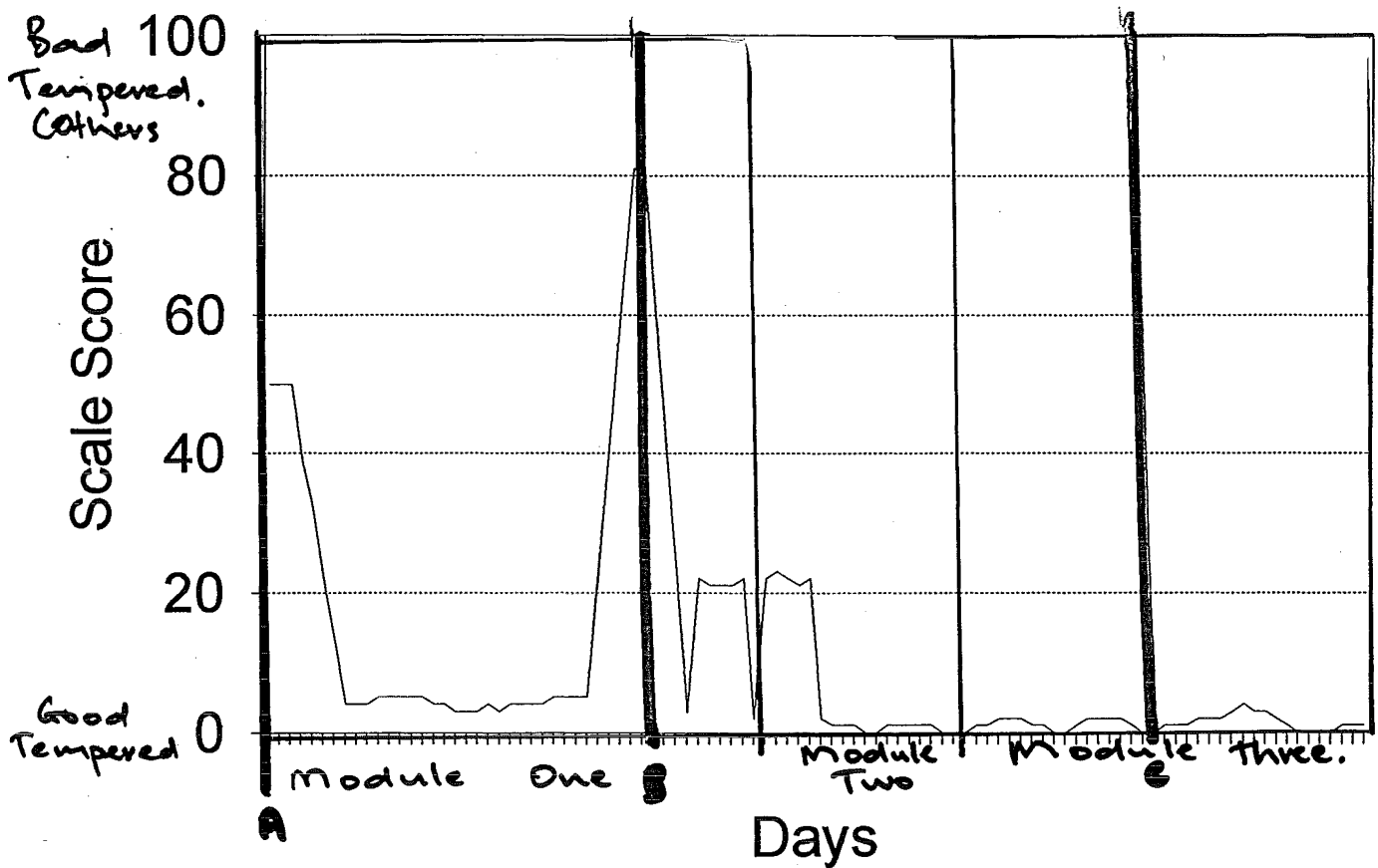


'Hotseat'

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact/Empathy.

Subject 6.

Sub 6 Scale 4

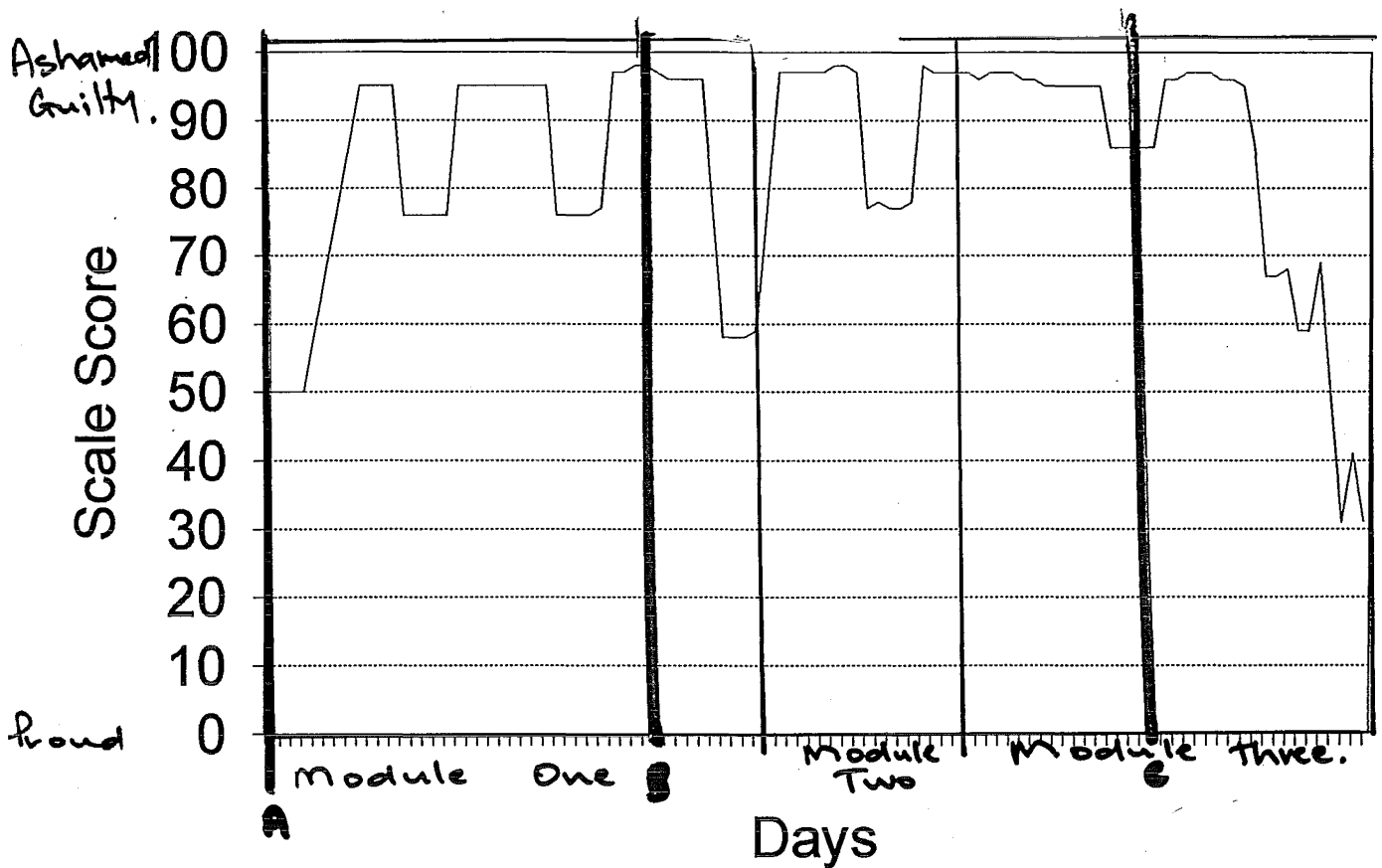


'Hotseat'

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 6.

Subject 6 Scale 5

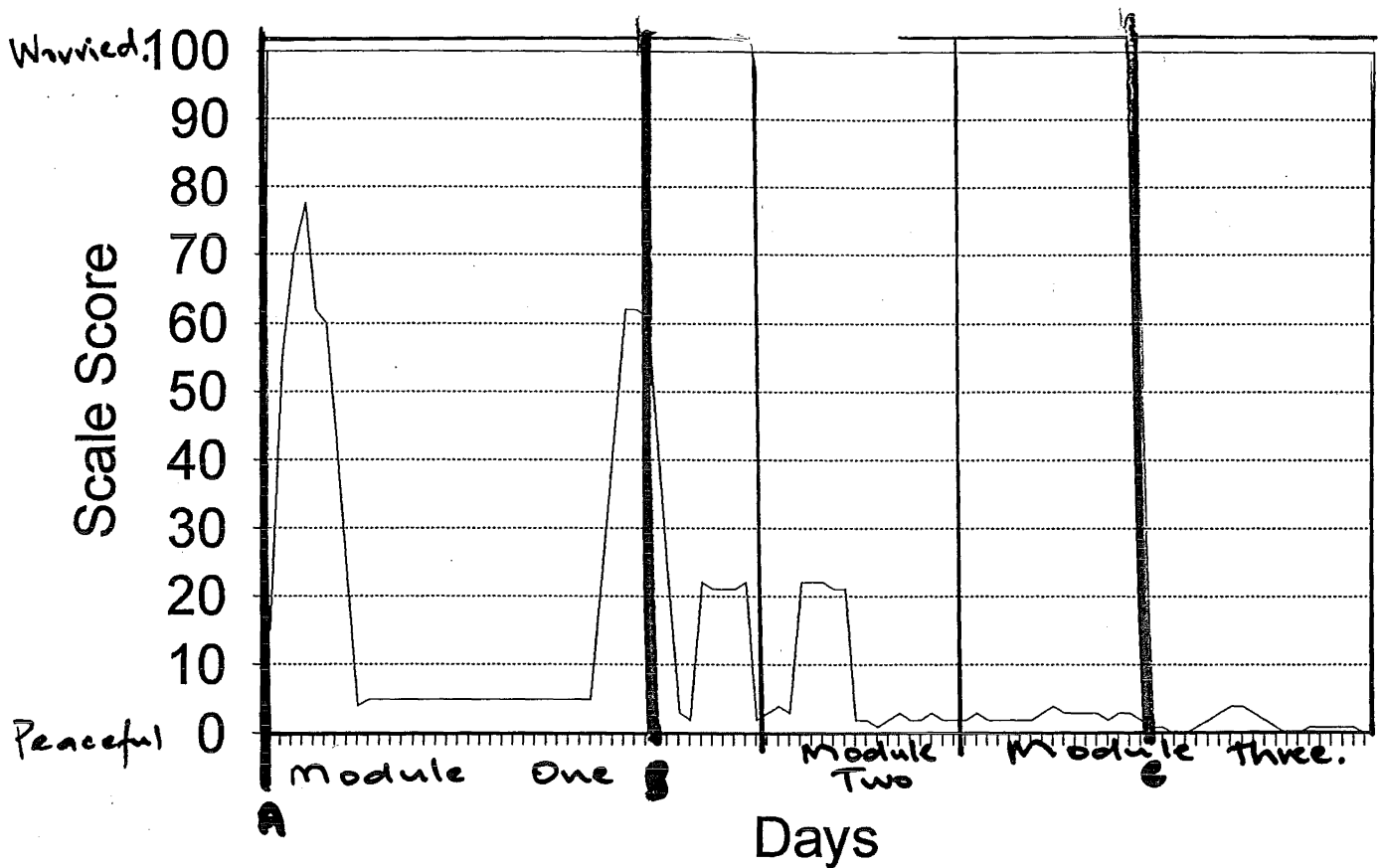


'Hotseat'

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact/Empathy.

Subject 6.

Subject 6 Scale 6

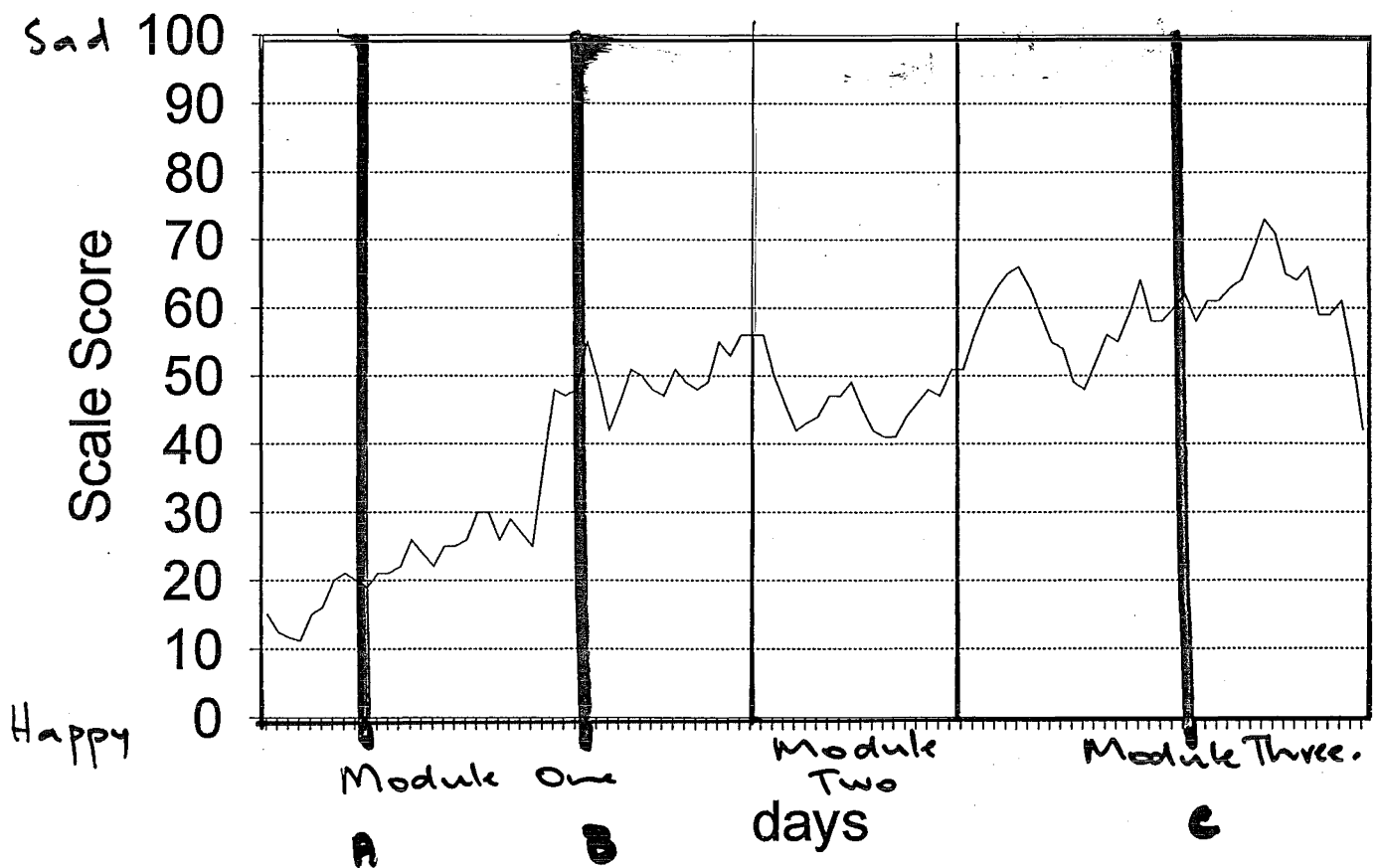


"Hotseat"

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 7.

Sub 7 Scale 1

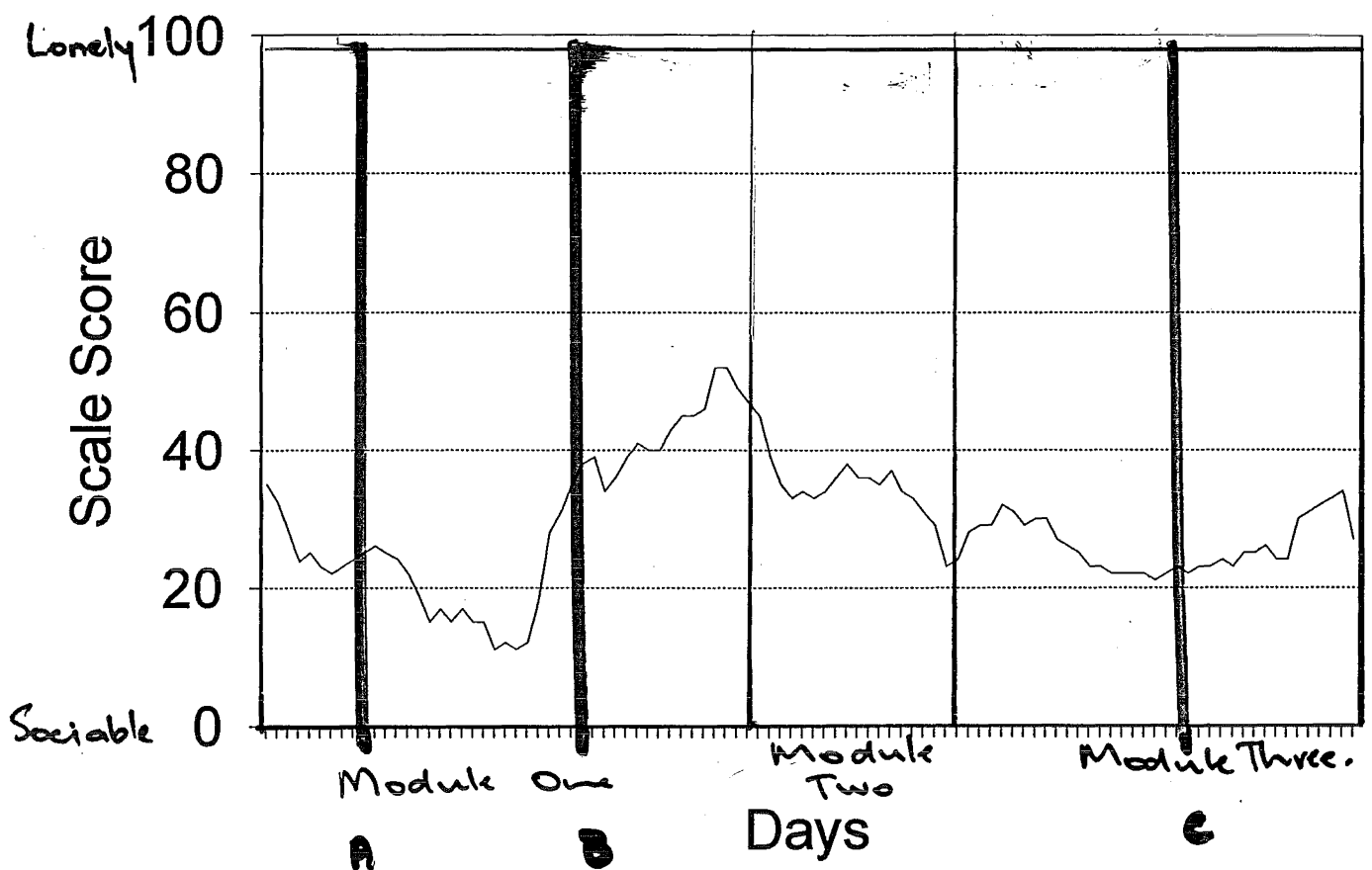


Hotseat"

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 7.

Sub 7 Scale 2

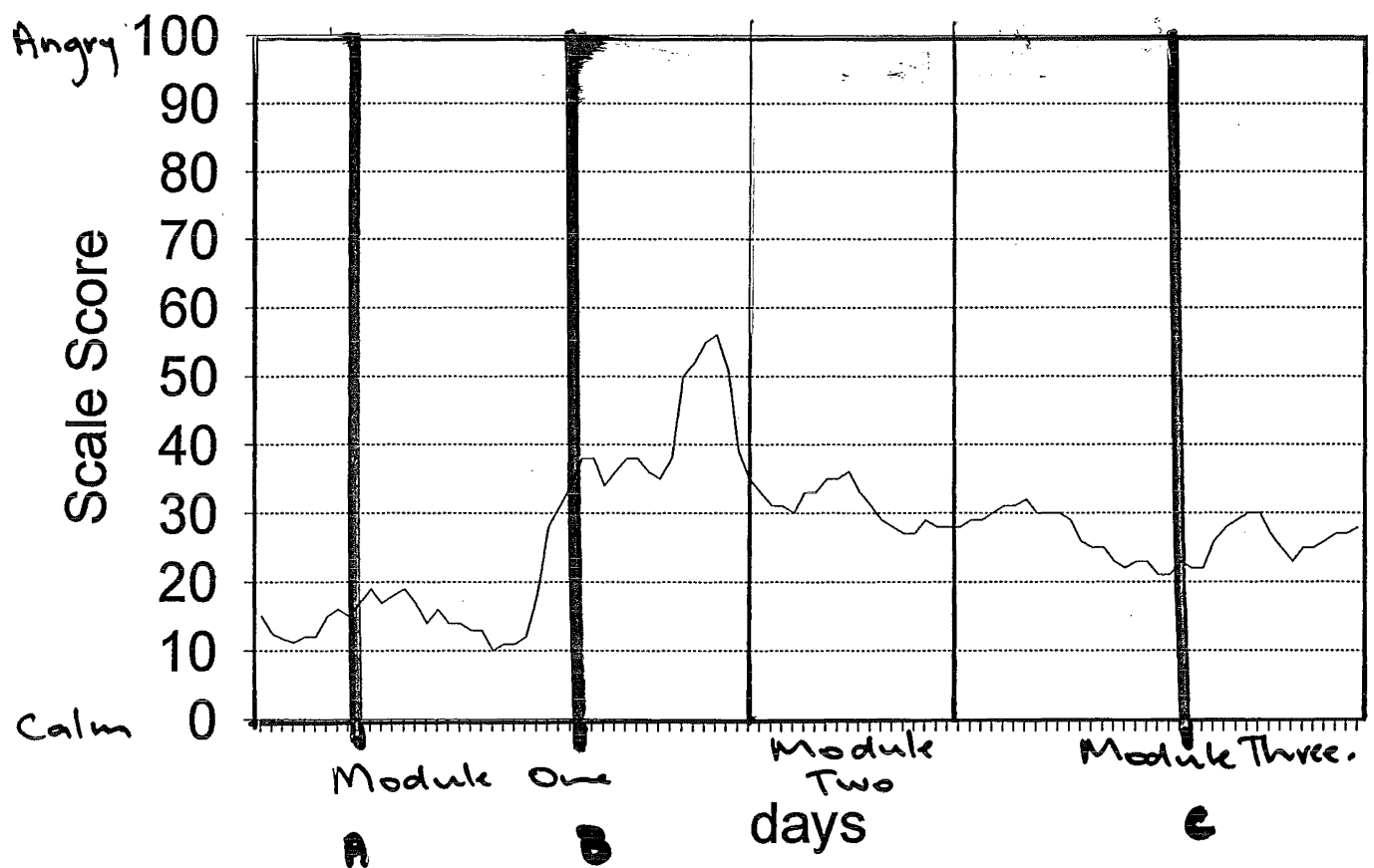


Hotseat[®]

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 7.

Sub 7 Scale 3

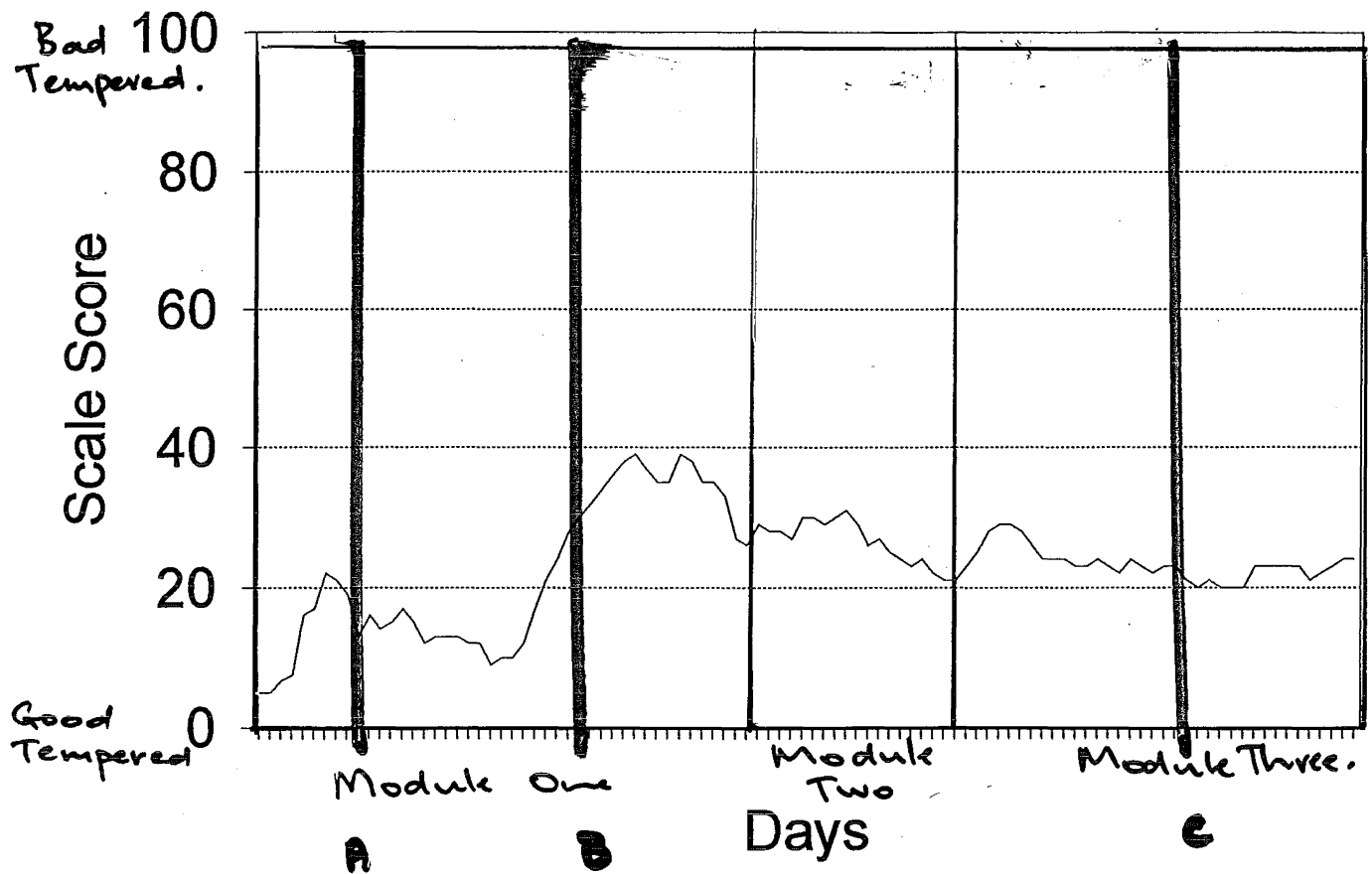


Hotseat[®]

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 7.

Sub 7 Scale 4

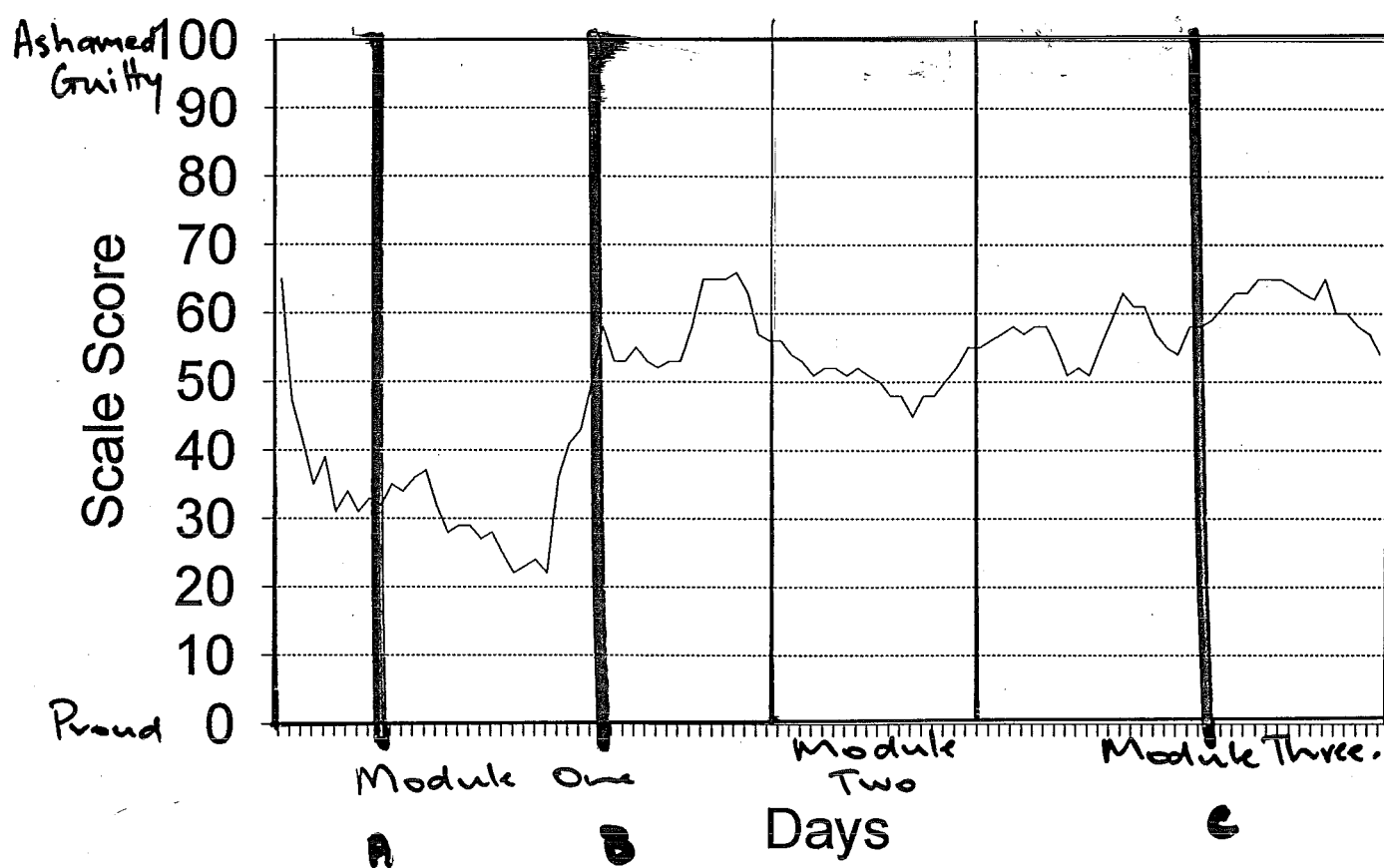


Hotseat"

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 7.

Sub 7 Scale 5

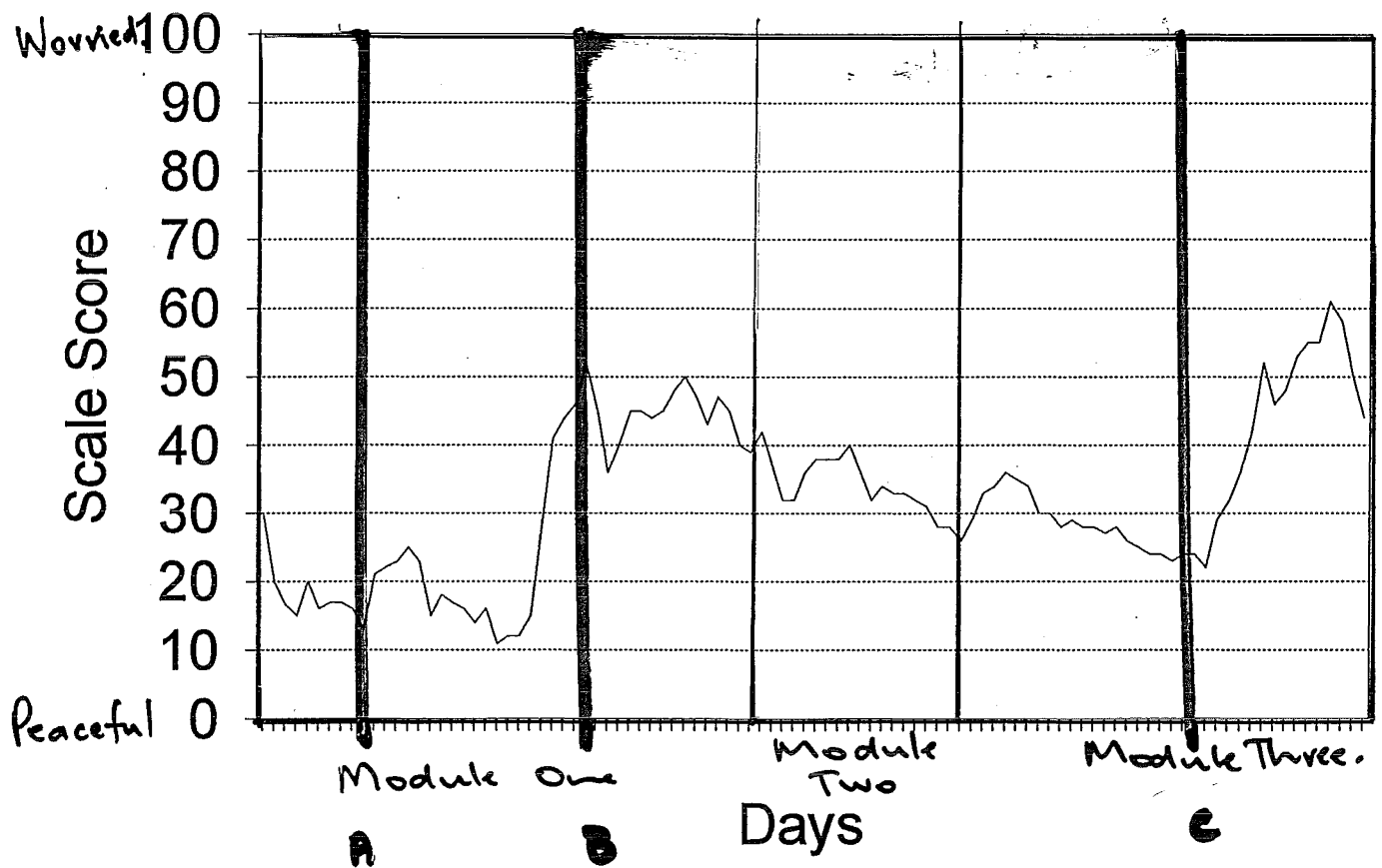


Hotseat

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 7.

Sub 7 Scale 6

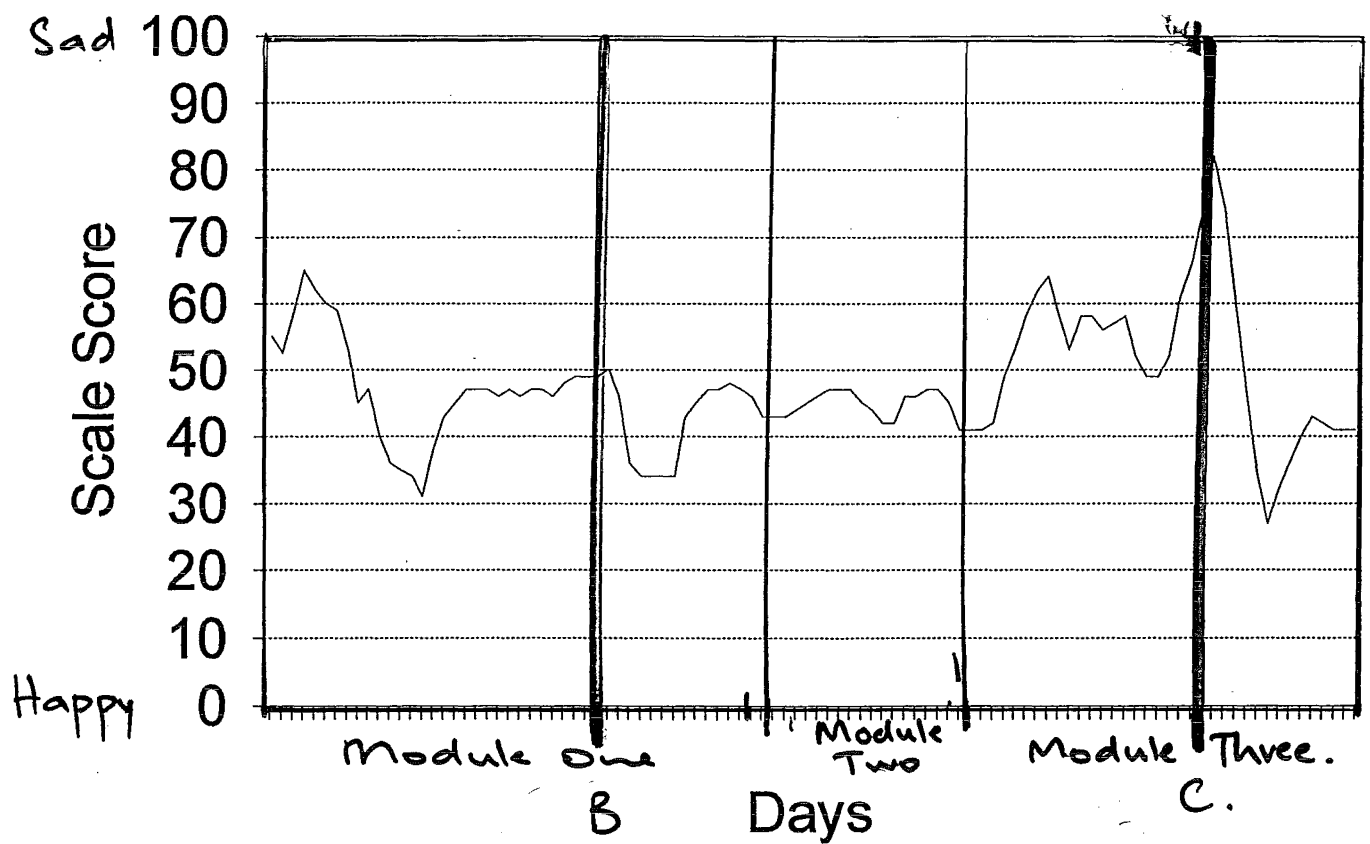


Hotseat*

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 8

Sub 8 Scale 1

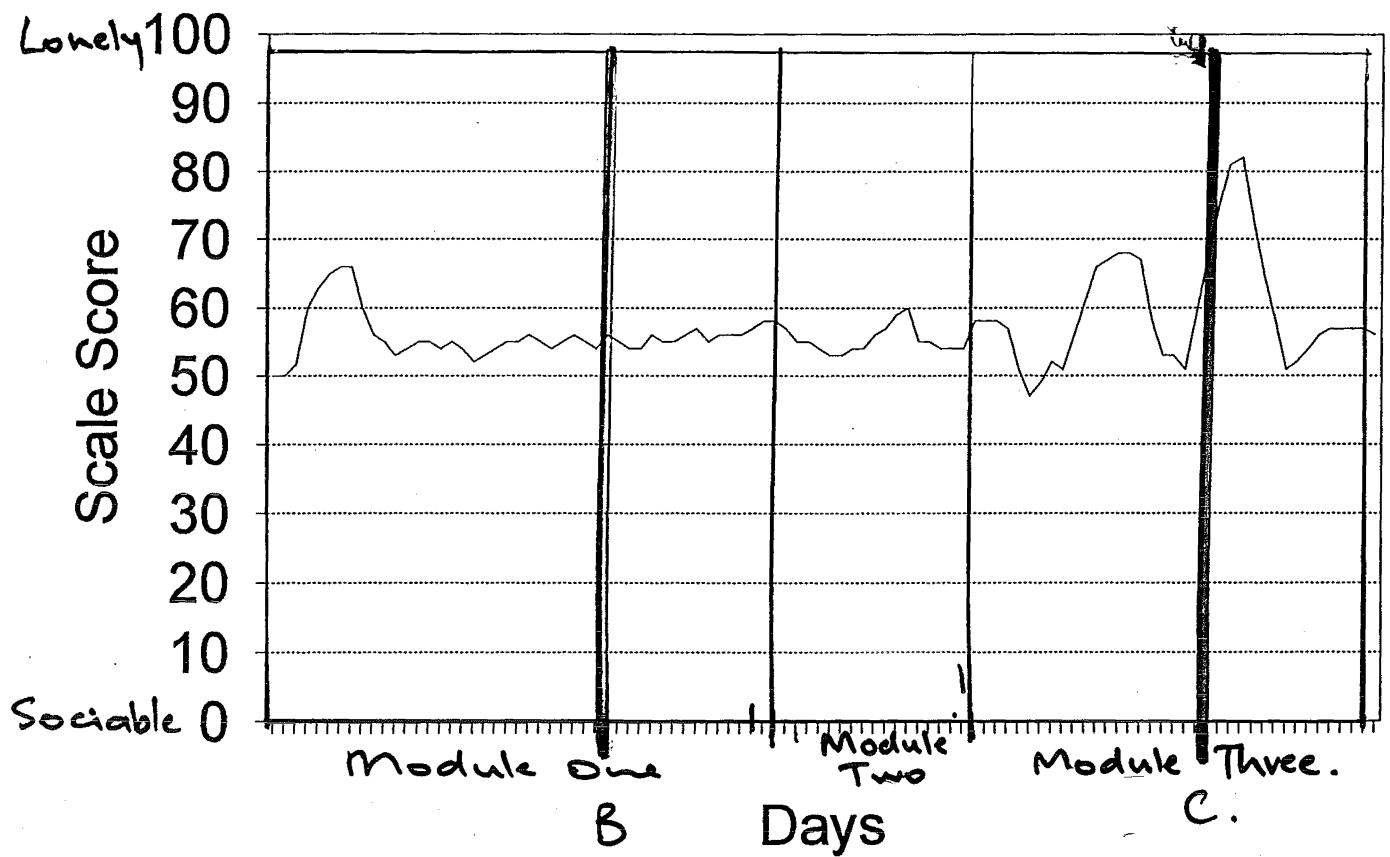


Hotseat[™]

- A - Not recorded.
- B - Cognitive Distortions Offence Cycle 2
- C - Victim Impact Empathy

Subject 8

Sub 8 Scale 2

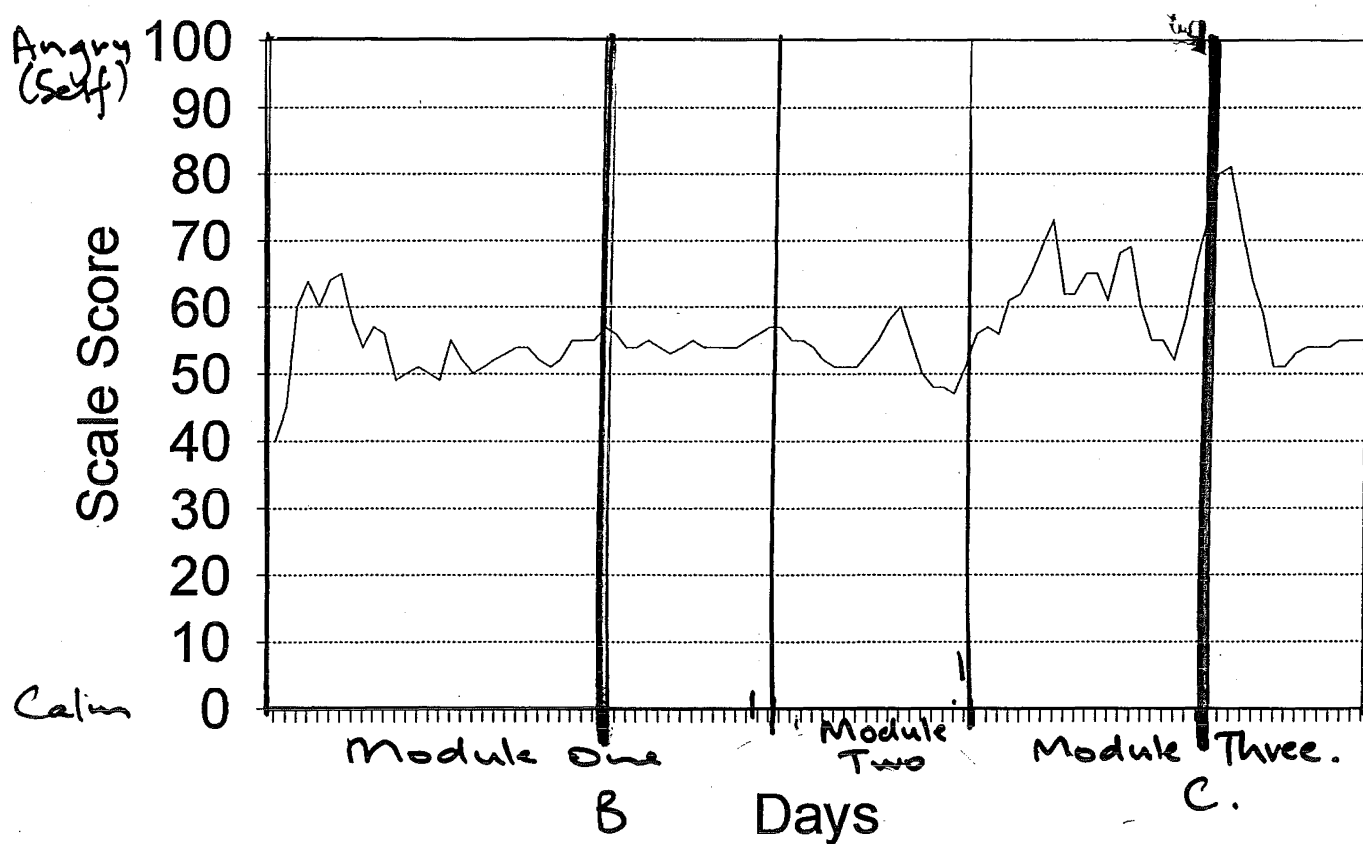


Hotseat™

- A - Not recorded.
- B - Cognitive Distortions Offence Cycle 2
- C - Victim Impact Empathy

Subject 8

Sub 8 Scale 3

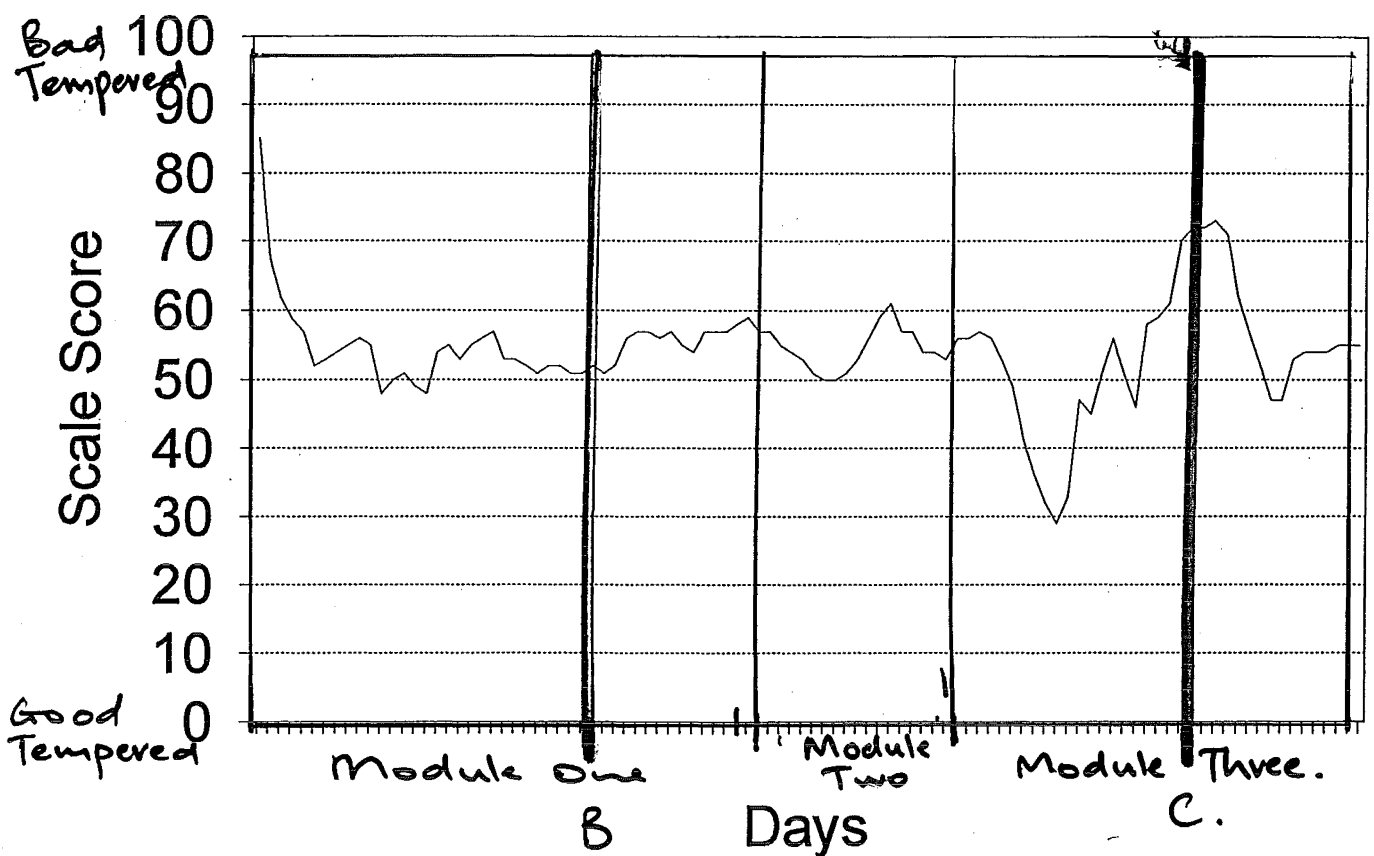


"Hotseat"

- A - Not recorded.
- B - Cognitive Distortions Offence Cycle 2
- C - Victim Impact Empathy

Subject 8

Sub 8 Scale 4

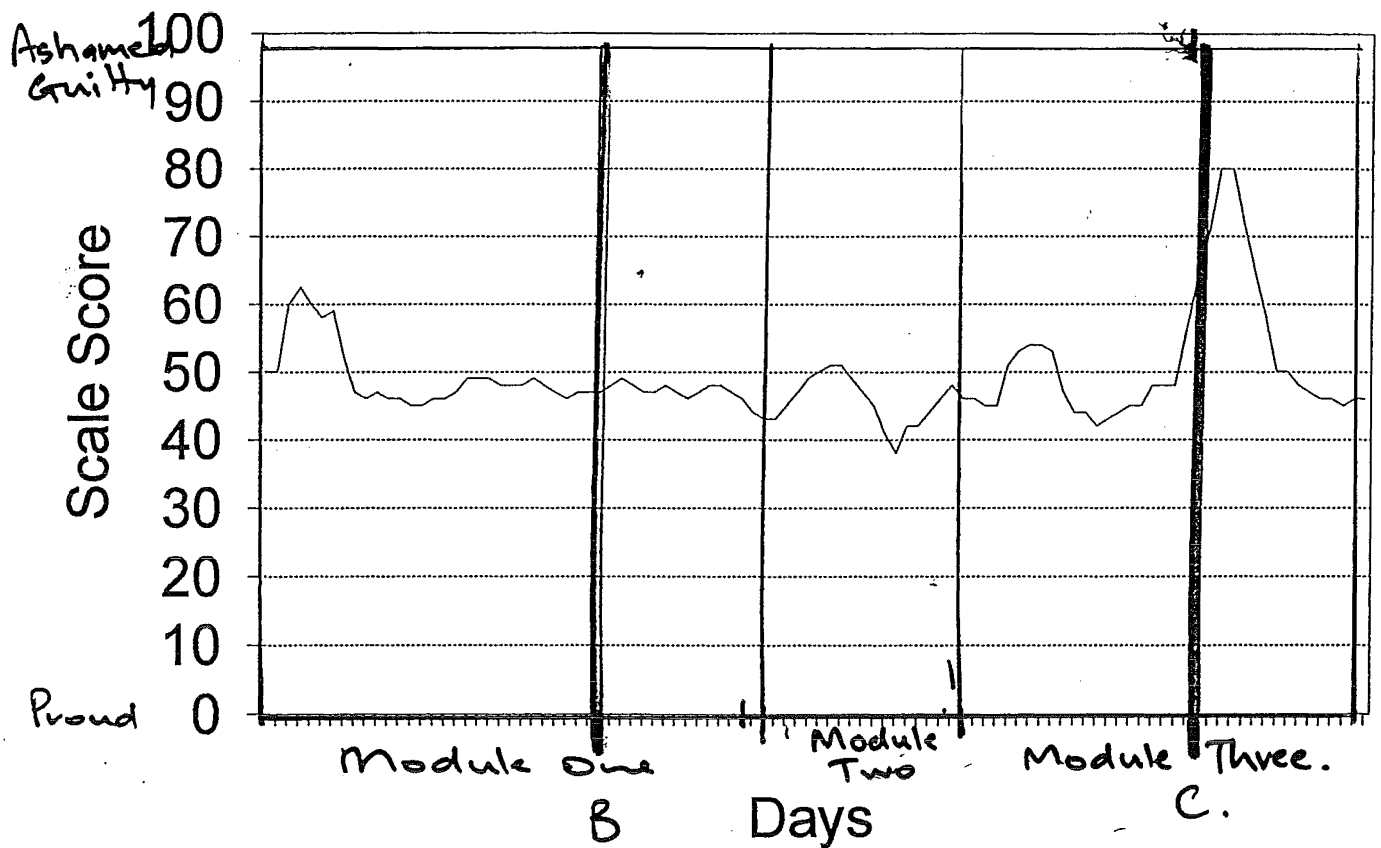


Hotseat™

- A - Not recorded.
- B - Cognitive Distortions Offence Cycle 2
- C - Victim Impact Empathy

Subject 8

Sub 8 Scale 5

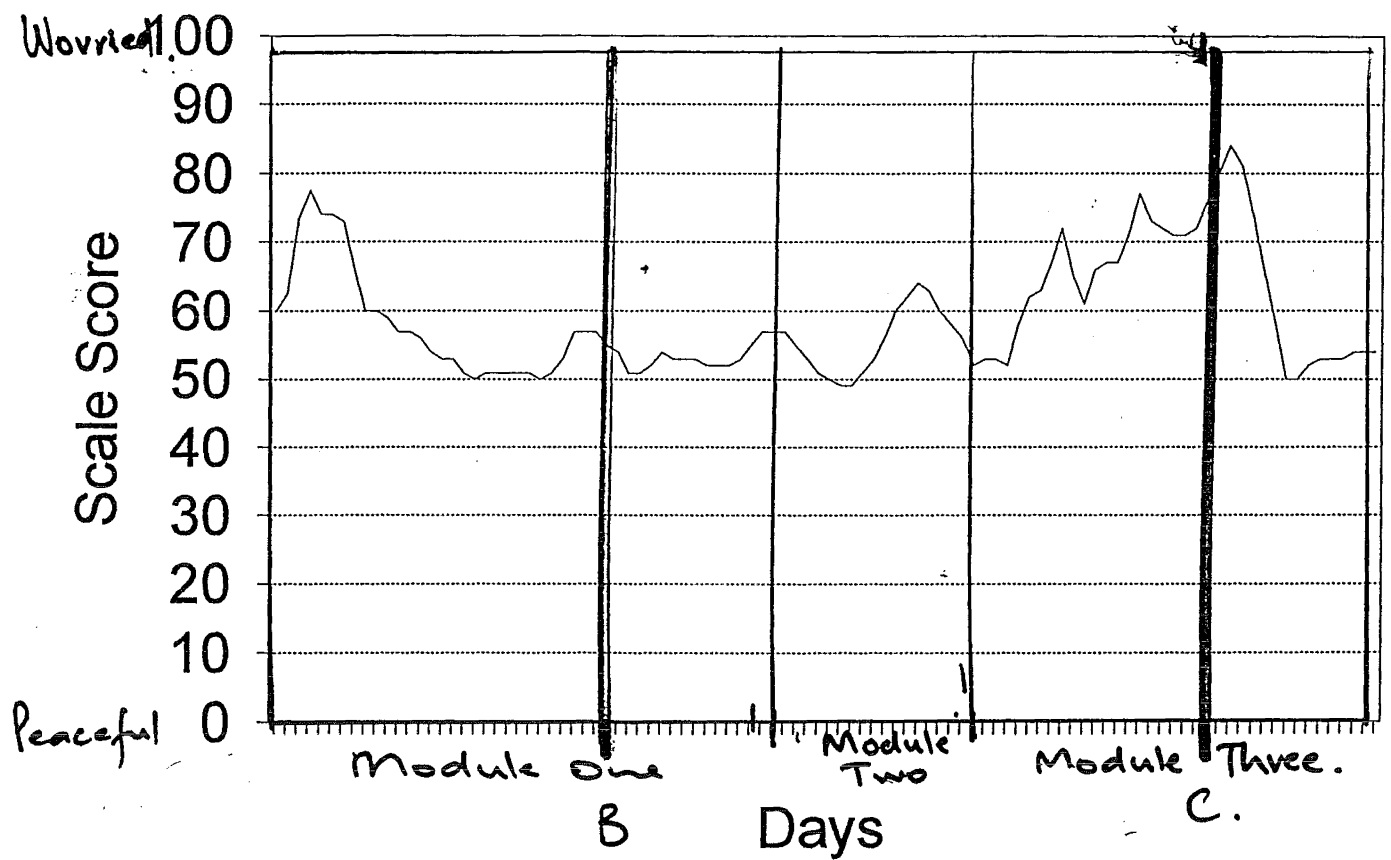


Hotseat^v

- A - Not recorded.
- B - Cognitive Distortions Offence Cycle 2
- C - Victim Impact Empathy

Subject 8

Sub 8 Scale 6

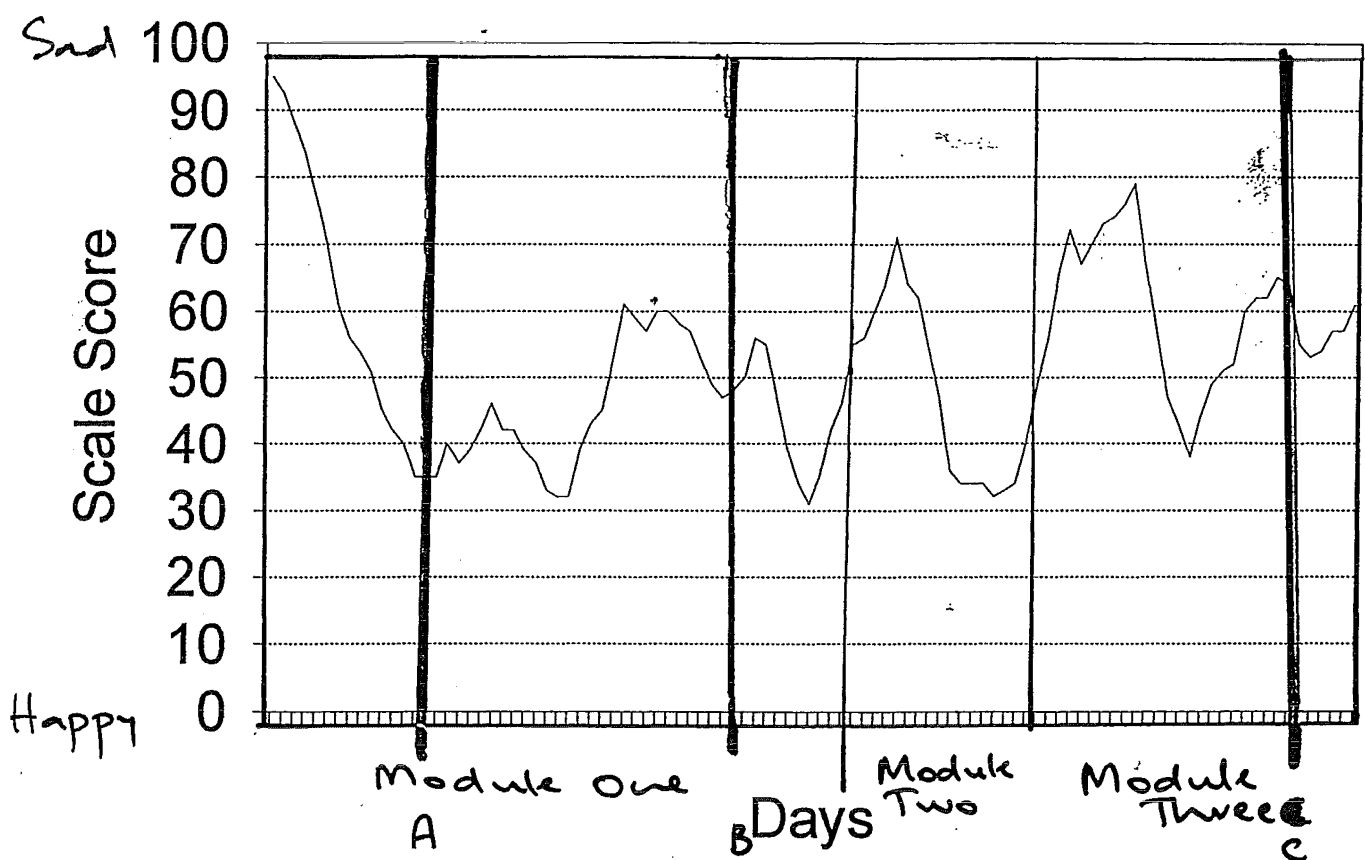


Hotseat

- A - Not recorded.
- B - Cognitive Distortions Offence Cycle 2
- C - Victim Impact Empathy

Subject 9.

Subject 9 Scale 1

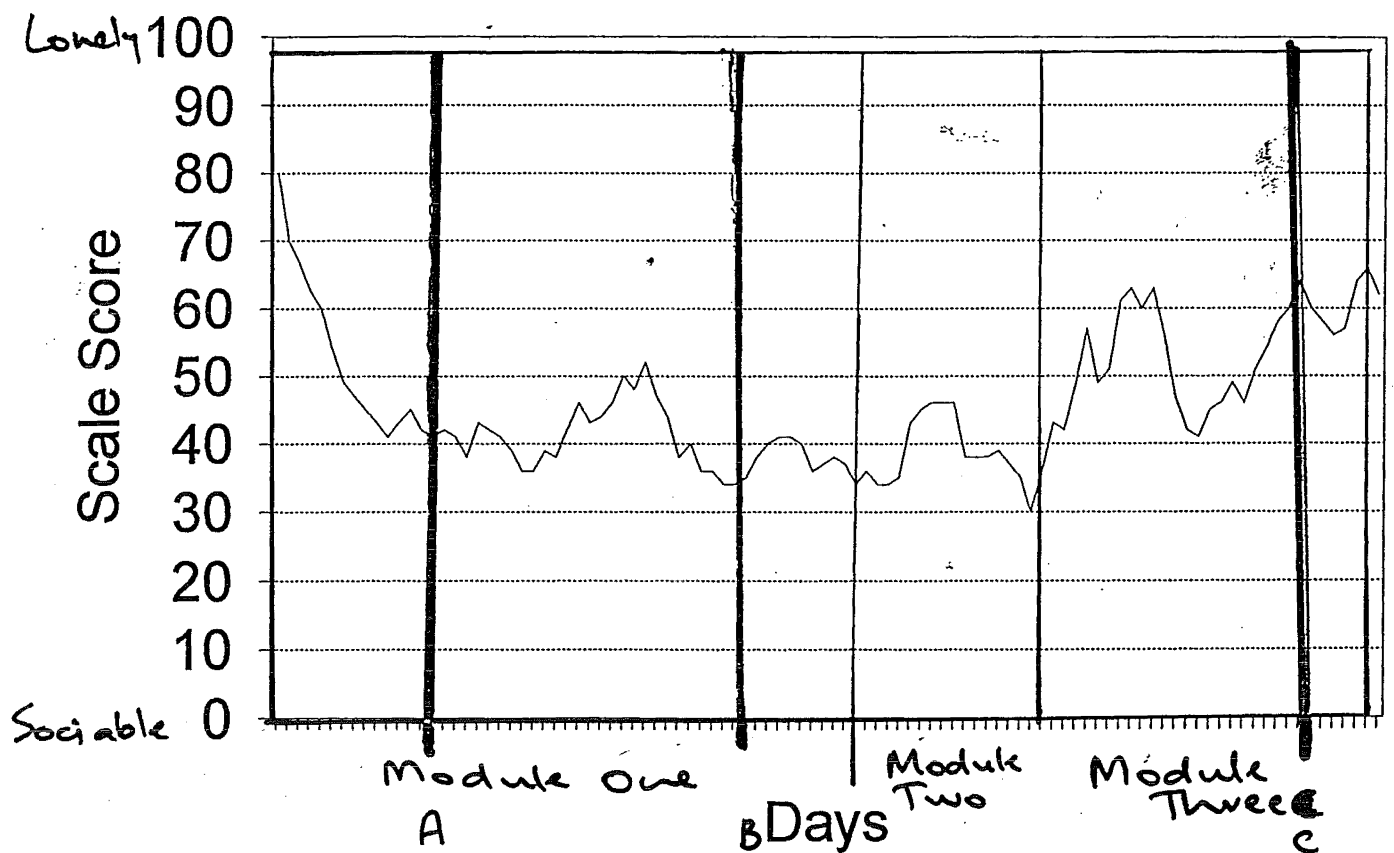


'Hotseat'

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 9.

Subject 9 Scale 2

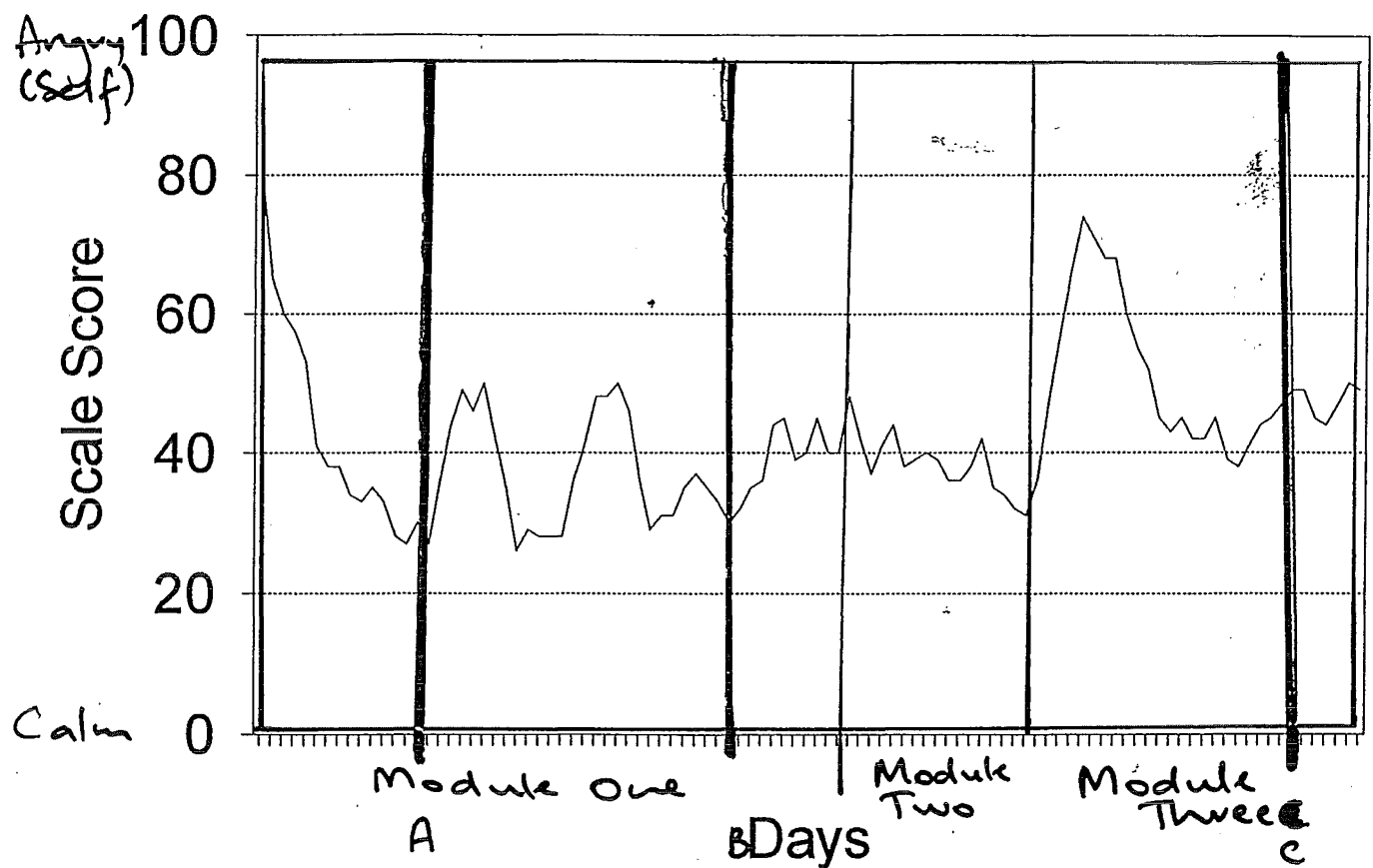


'Hotseat'

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 9.

Subject 9 Scale 3

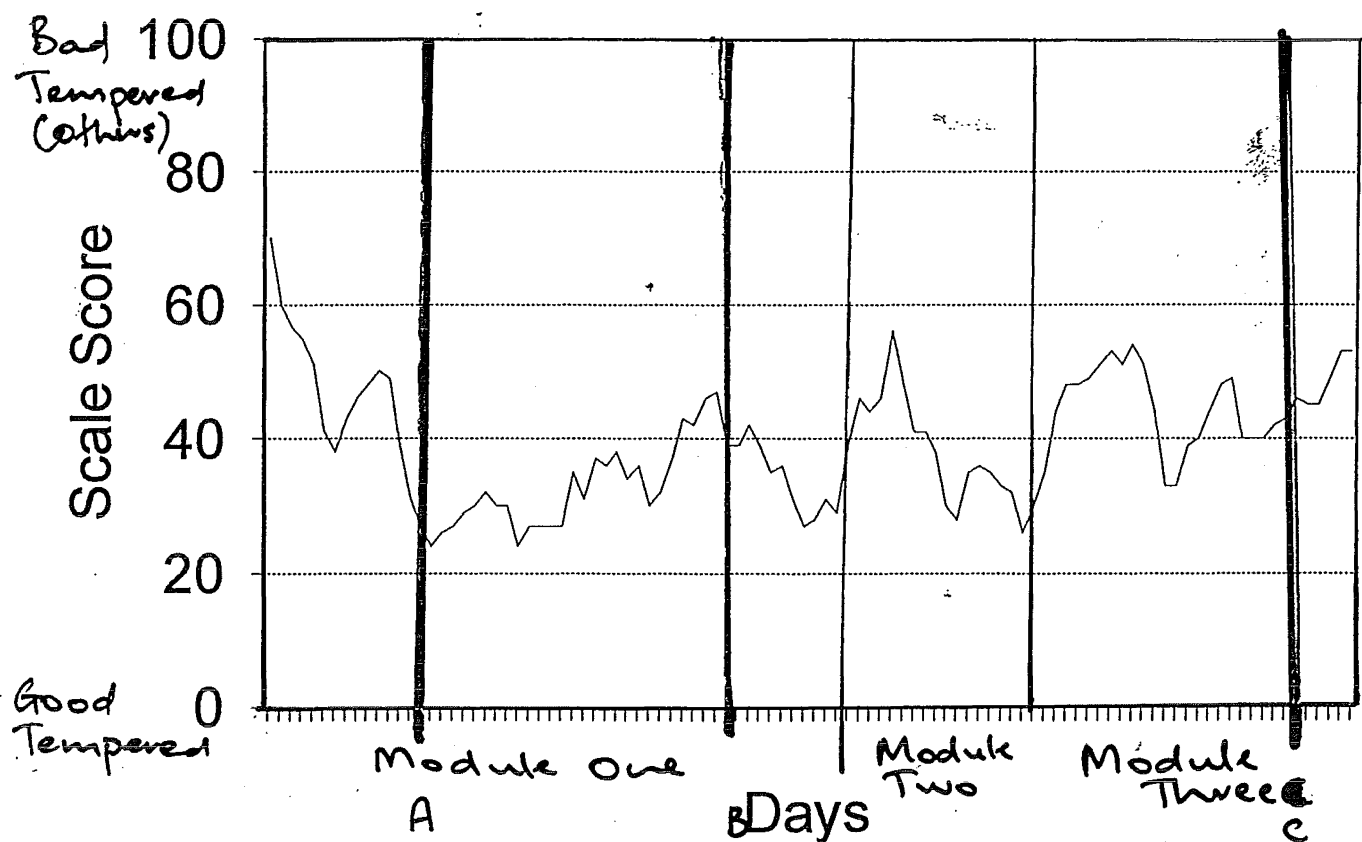


'Holseat'

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 9.

Subject 9 Scale 4

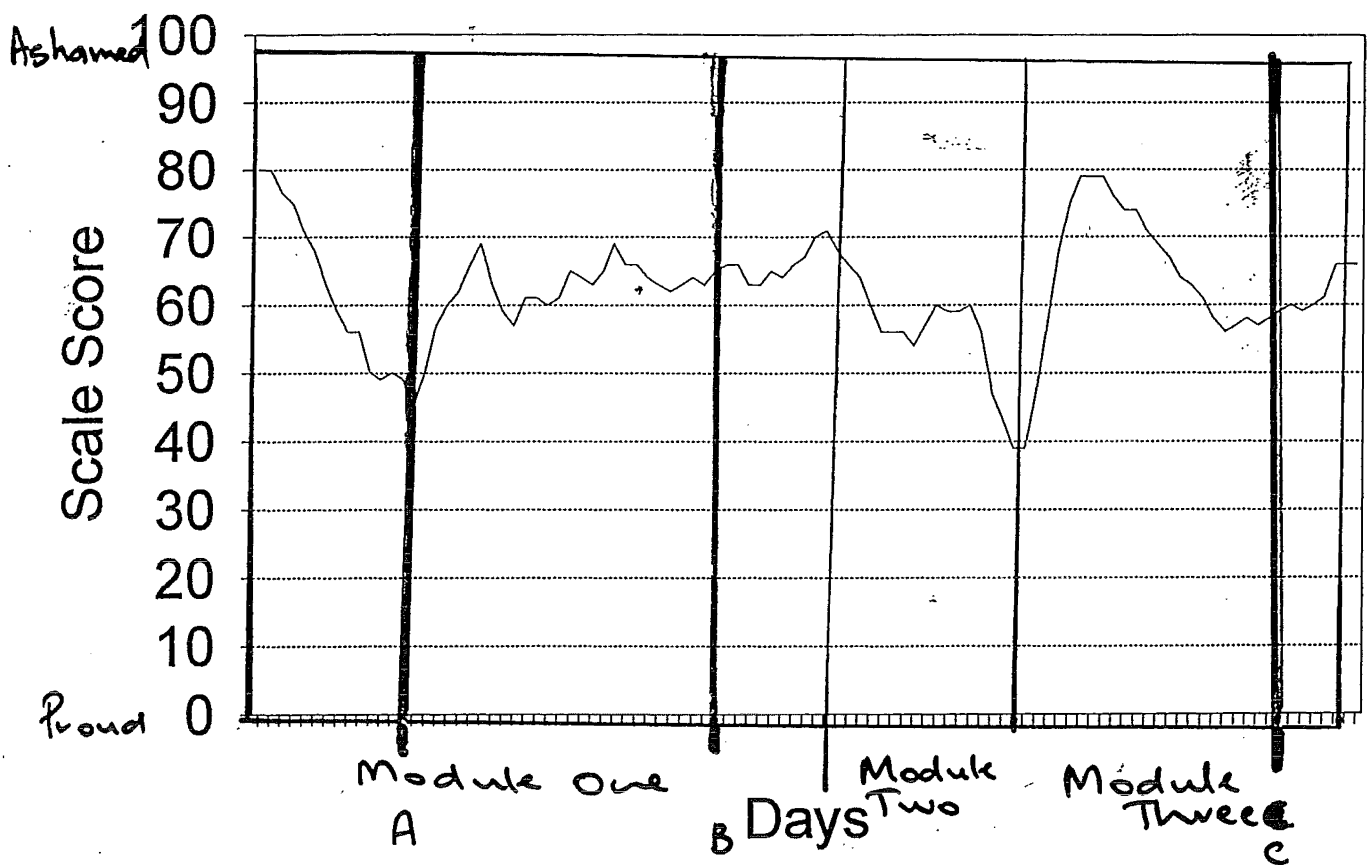


• Holseat •

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 9.

Subject 9 Scale 5

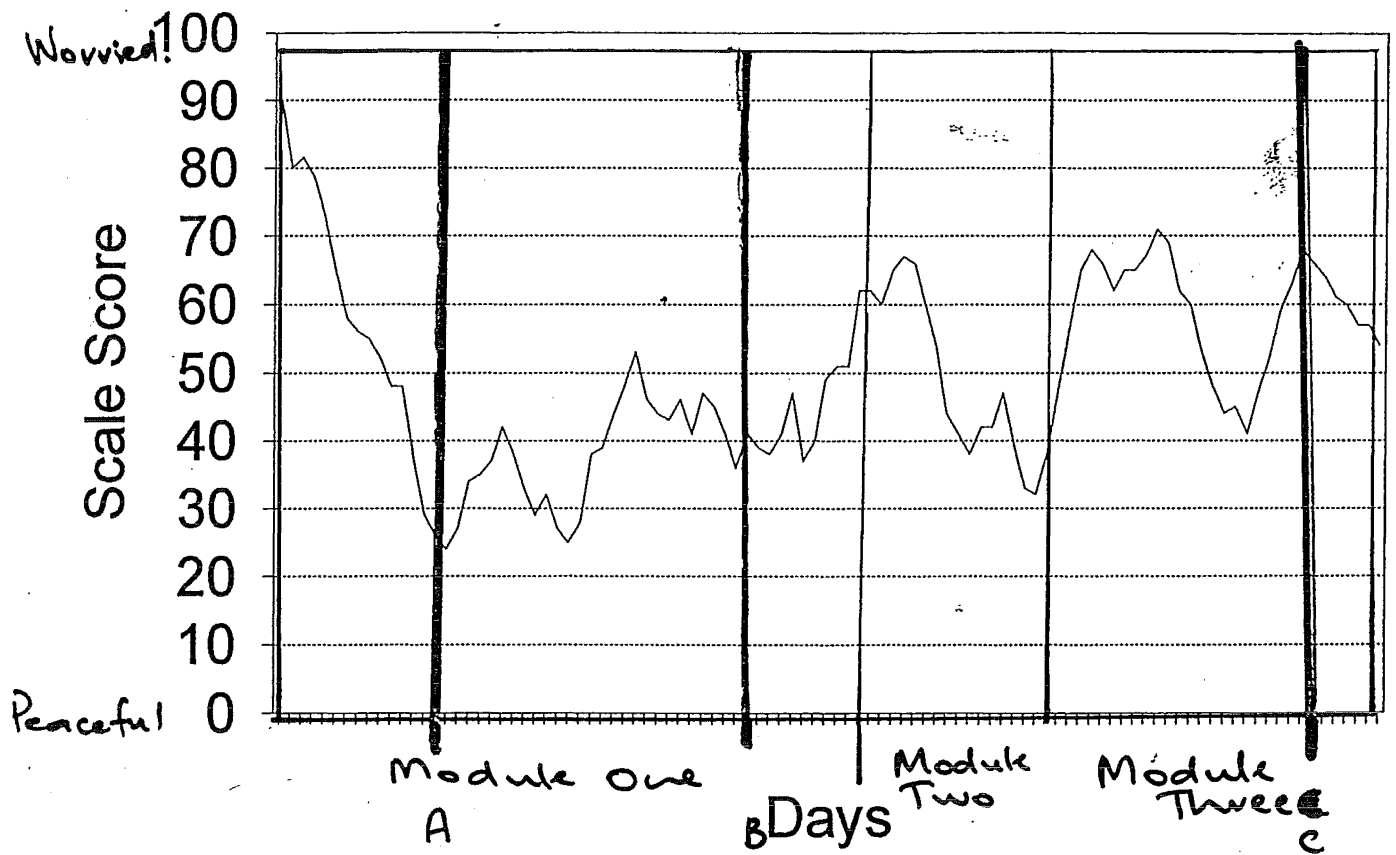


"Holscat"

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 9.

Subject 9 Scale 6

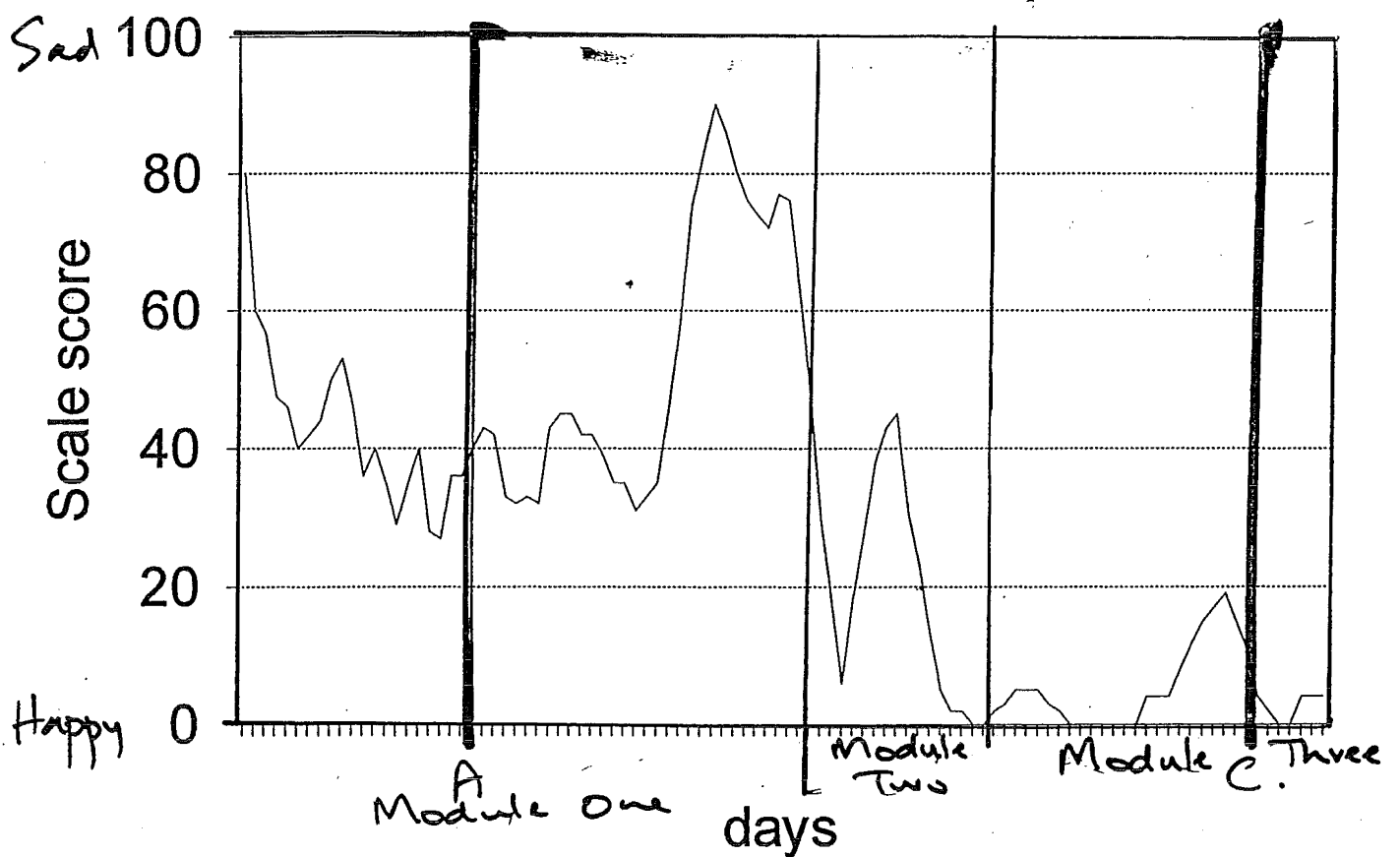


• Holseat •

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 10

Subject 10 Scale 1

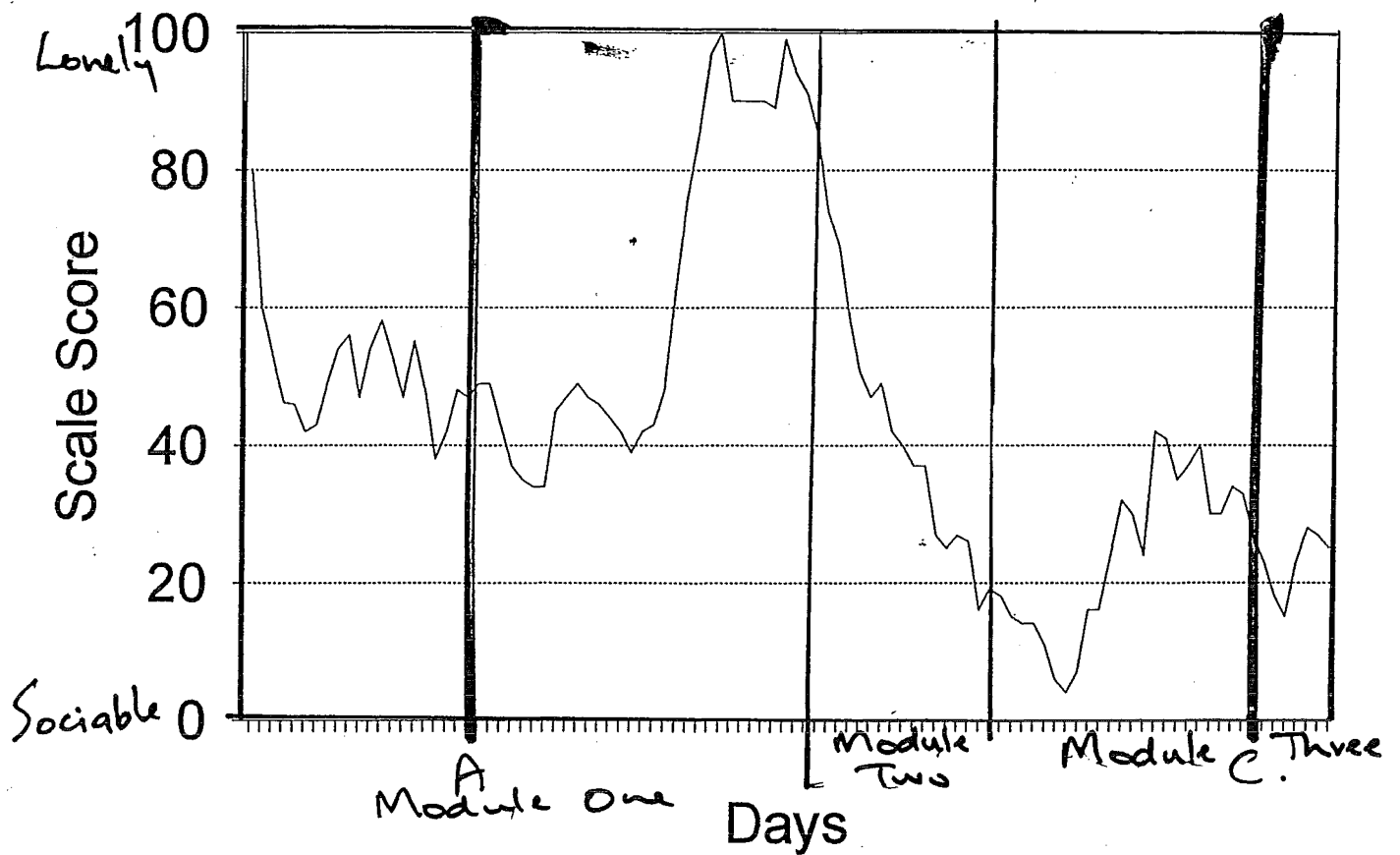


"Absent"

A. Cognitive Distortions. Offense Cycle
B. Not Rewarded.
C. Victim Impact/Empath.

Subject 10

Subject 10 Scale 2

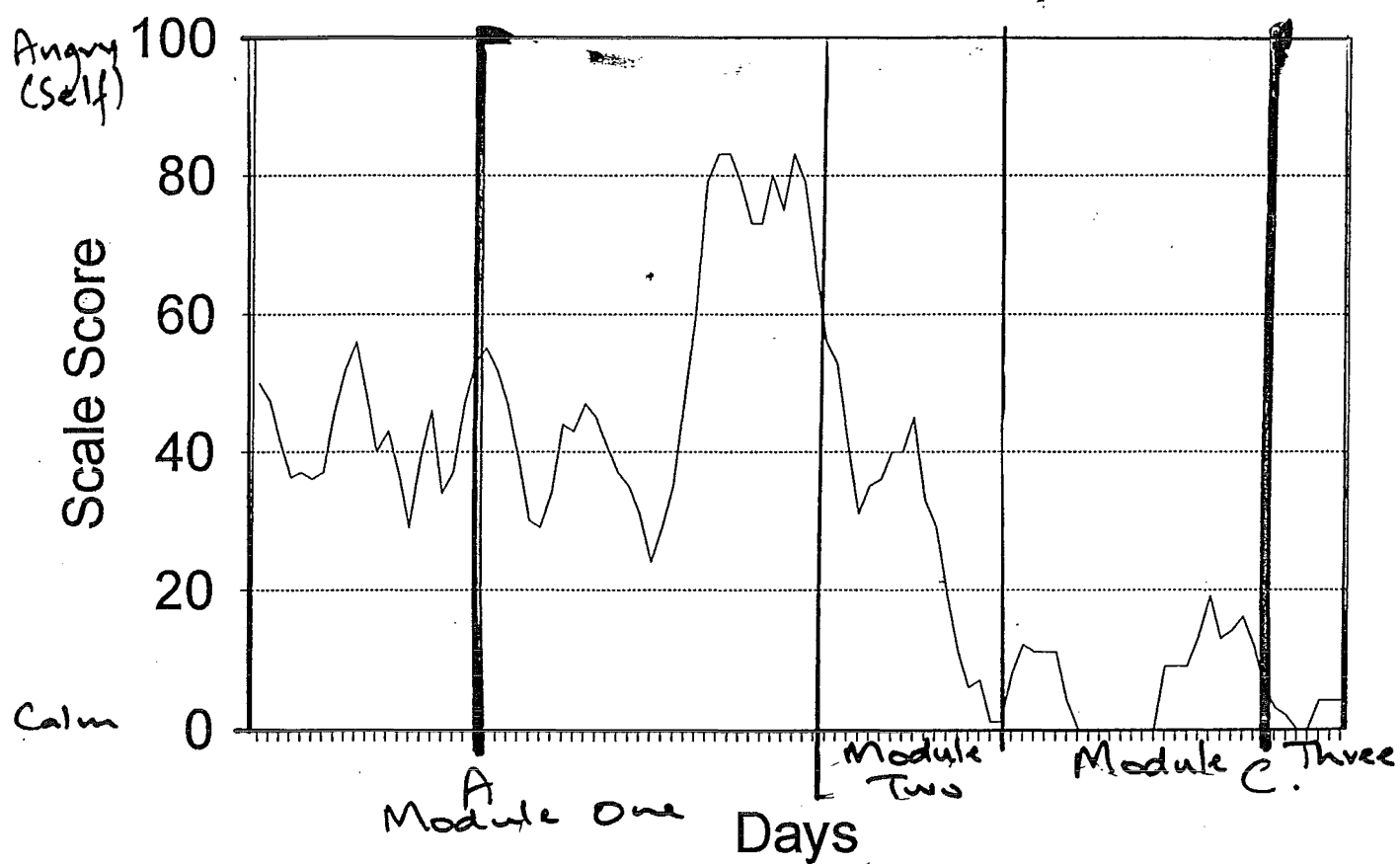


"Hotseat"

A. Cognitive Distortions. Offense Cycle
B. Not Rewarded.
C. Victim Impact/Empath.

Subject 10

Subject 10 Scale 3

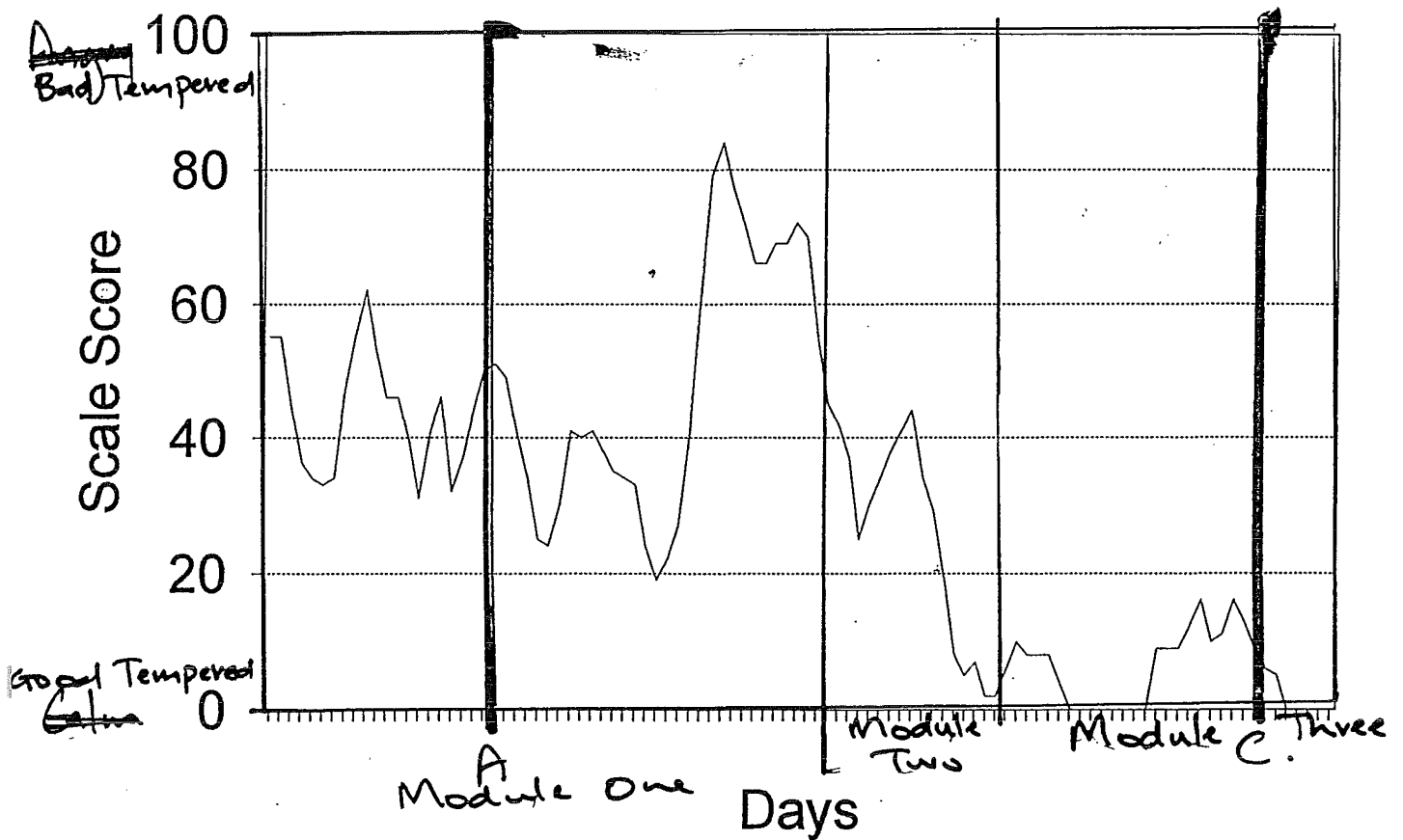


"Hotseat"

A. Cognitive Distortions. Offense Cycle
B. Not Recorded.
C. Victim Impact/Empath.

Subject 10

Subject 10 Scale 4

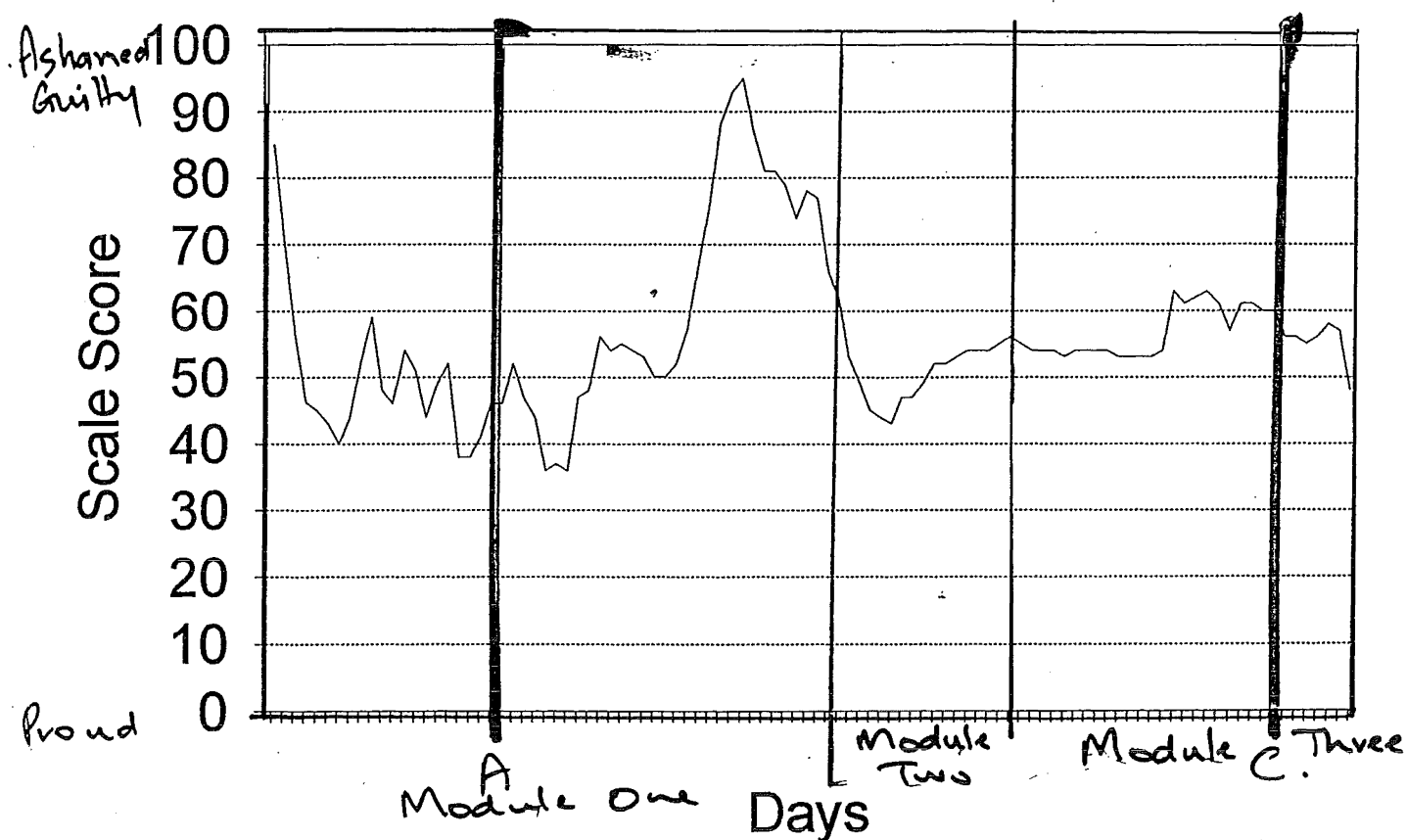


"Hotseat"

A. Cognitive Distortions. Offense Cycle
B. Not Recorded.
C. Victim Impact/Empath.

Subject 10

Subject 10 Scale 5

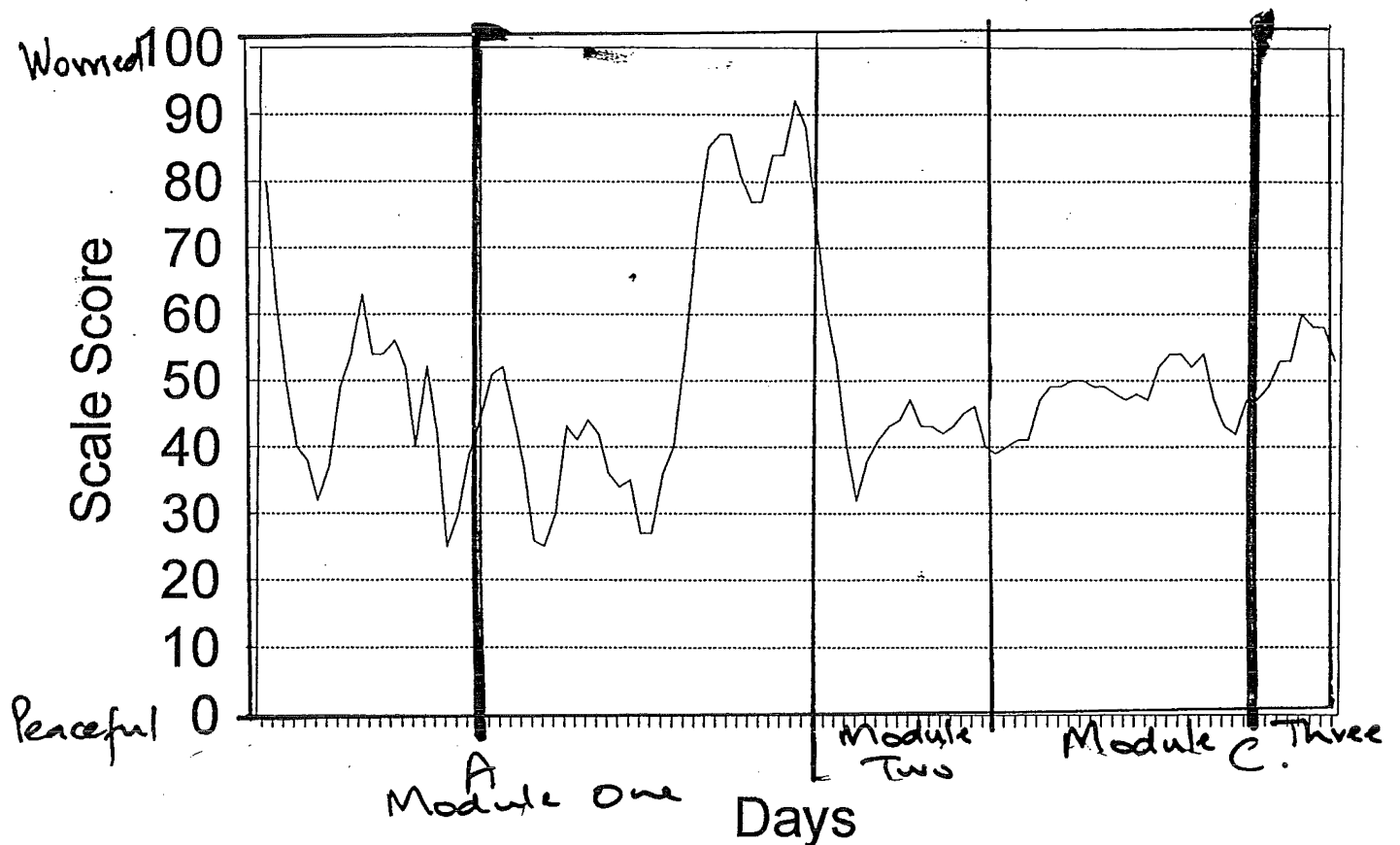


"Antisocial"

- A. Cognitive Distortions. Offense Cycle
- B. Not Rewarded.
- C. Victim Impact/Empathy.

Subject 10

Subject 10 Scale 6

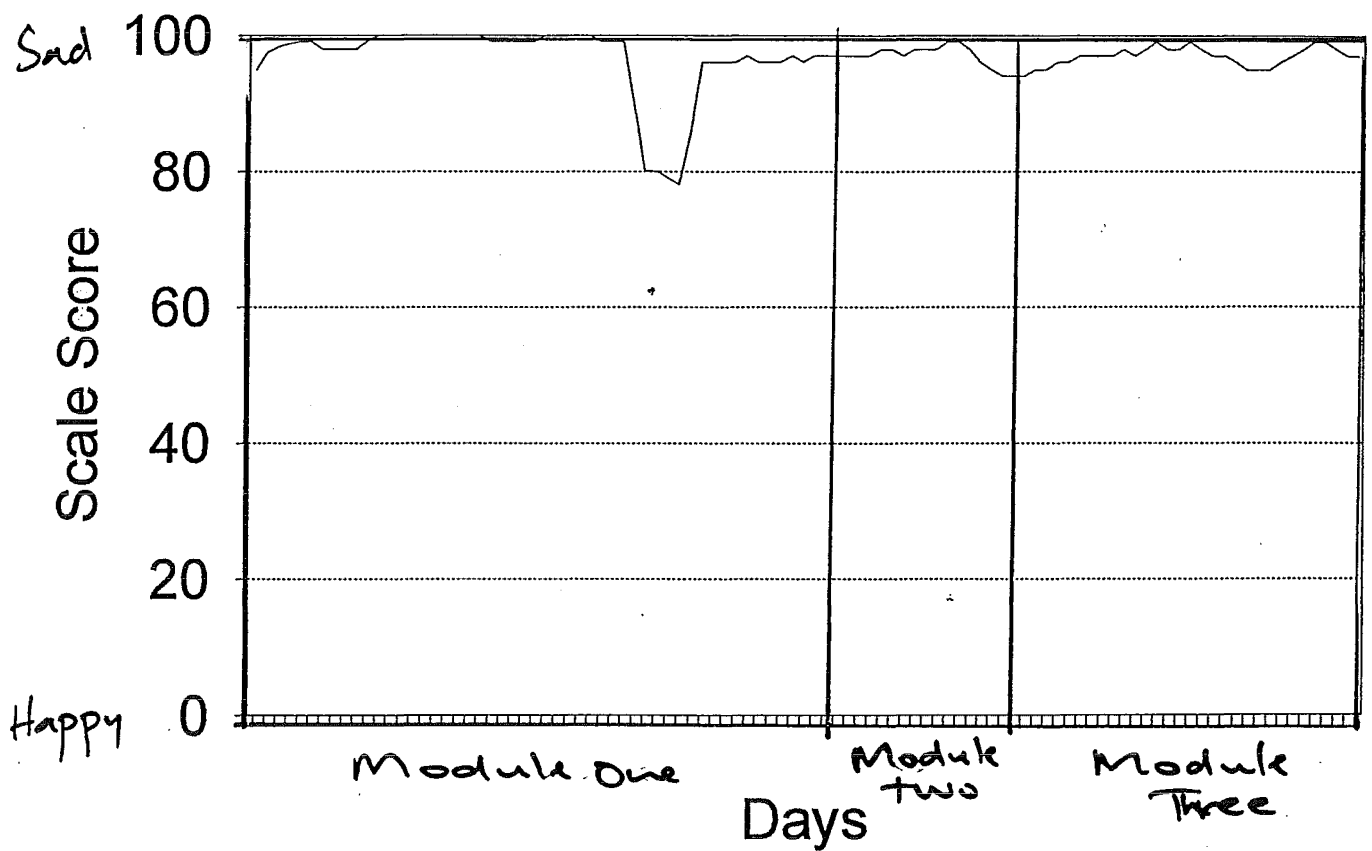


"Hotseat"

- A. Cognitive Distortions. Offense Cycle
- B. Not Rewarded.
- C. Victim Impact/Empath.

Subject 11.

Subject 11 Scale 1

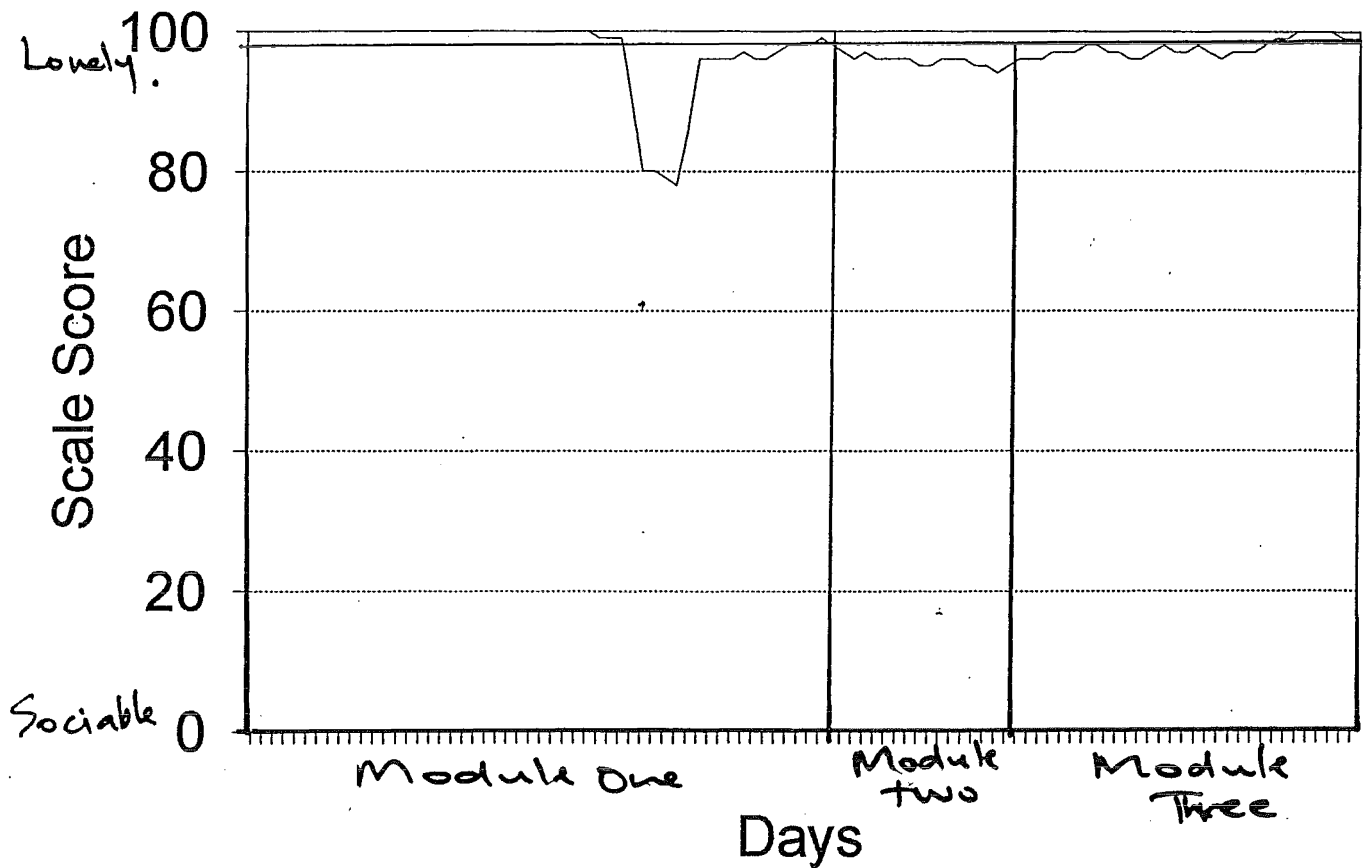


'Holseat'

A Not Recorded
B Not Recorded
C Not Recorded.

Subject 11.

Subject 11 Scale 2

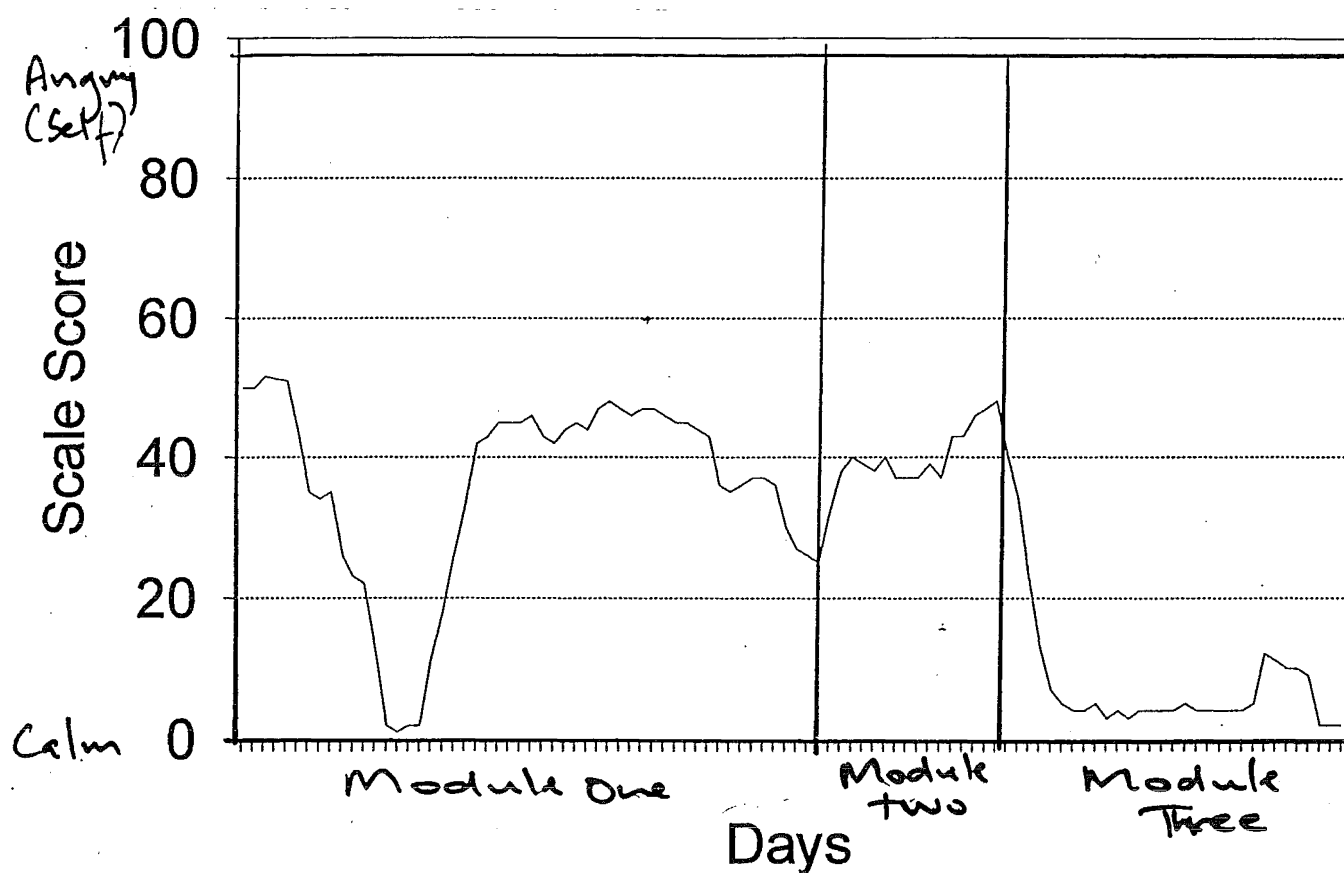


"Hotseat"

A	Not Recorded
B	Not Recorded
C	Not Recorded.

Subject 11.

Subject 11 Scale 3

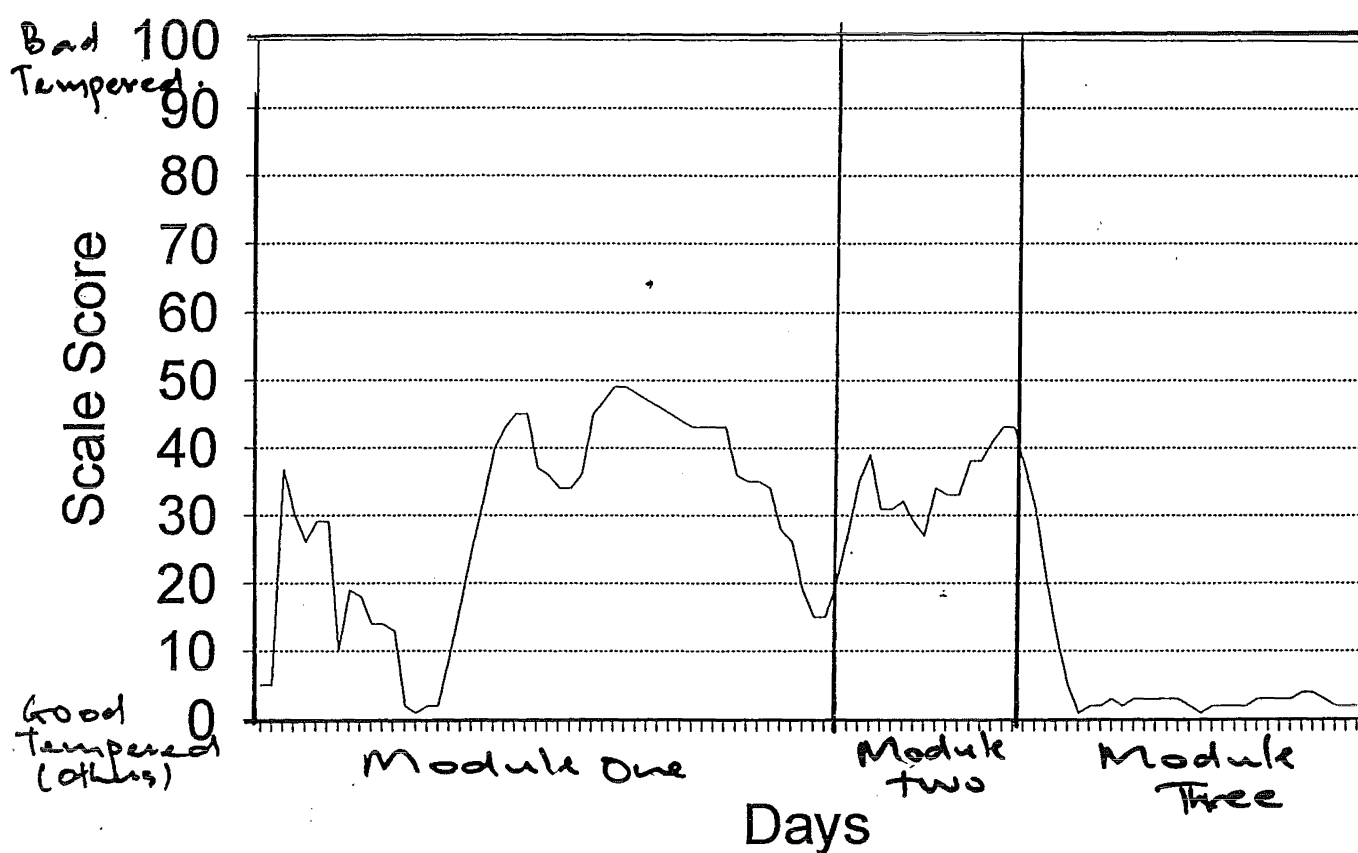


'Hotseat'

A Not Recorded
B Not Recorded
C Not Recorded.

Subject 11.

Subject 11 Scale 4

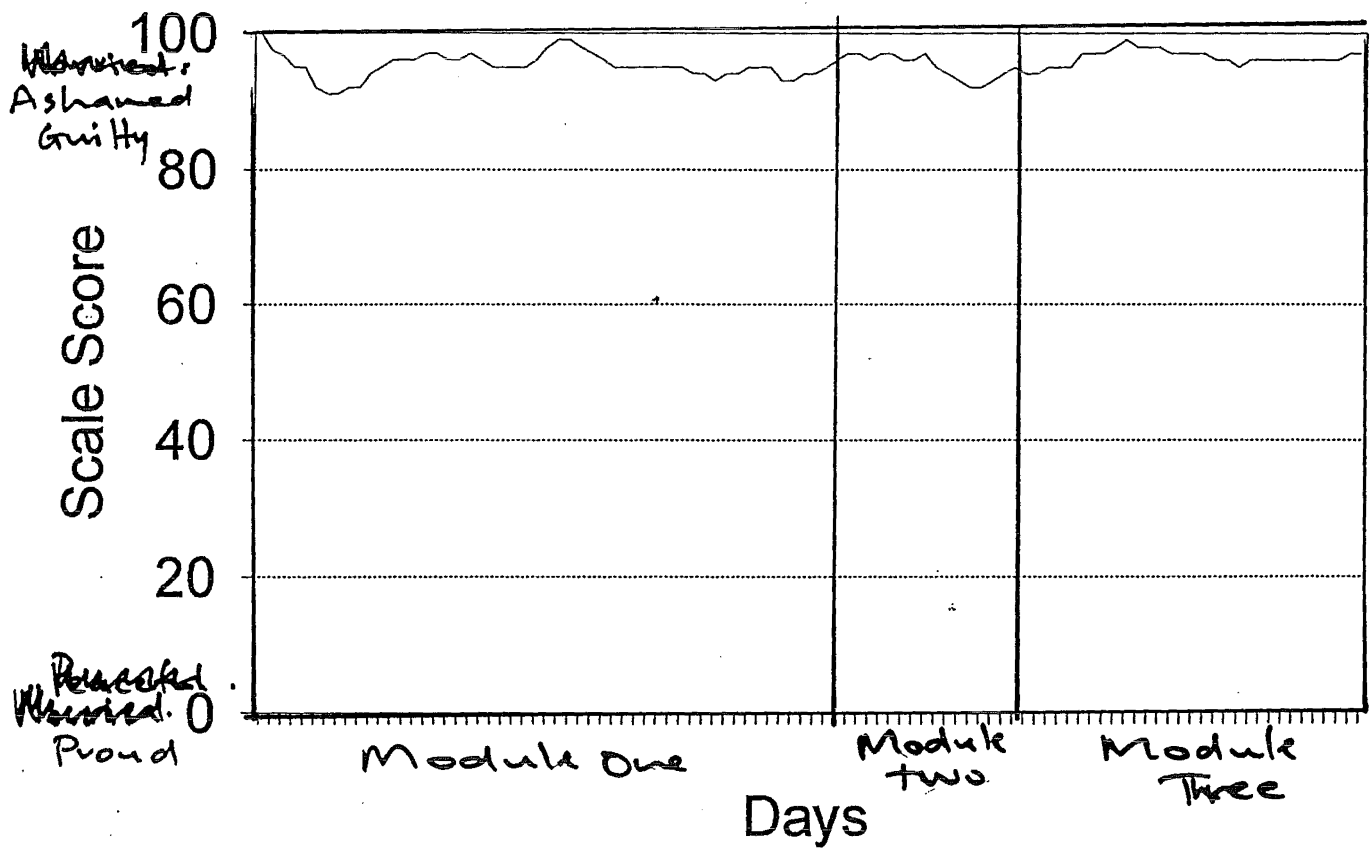


"Hotseat"

A Not Recorded
B Not Recorded
C Not Recorded.

Subject 11.

Subject 11 Scale 5

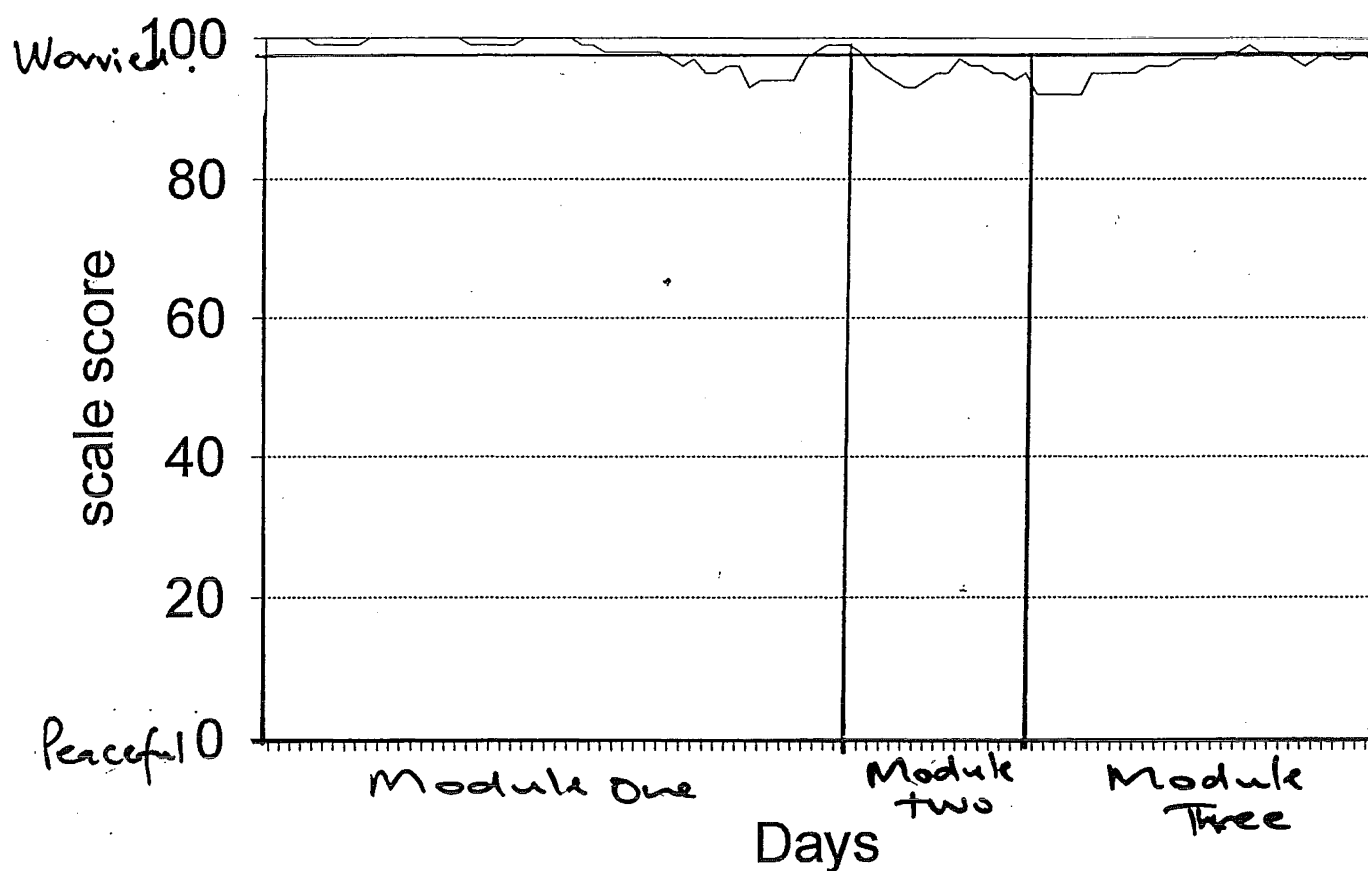


"Hotseat"

A	Not Recorded
B	Not Recorded
C	Not Recorded

Subject 11.

Subject 11 Scale 6

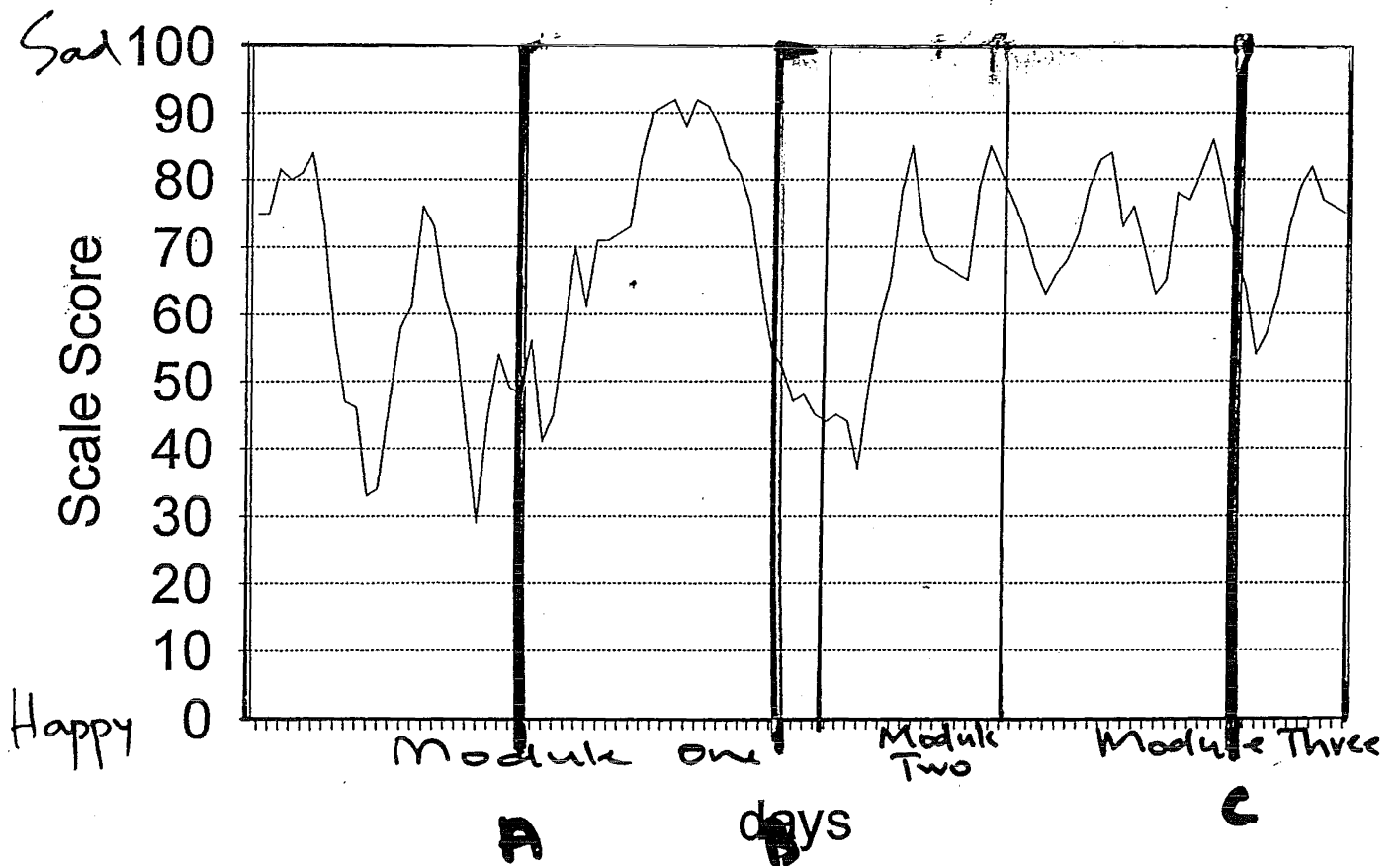


"Hotseat"

A Not Recorded
B Not Recorded
C Not Recorded.

Subject 12.

Subject 12 Scale 1

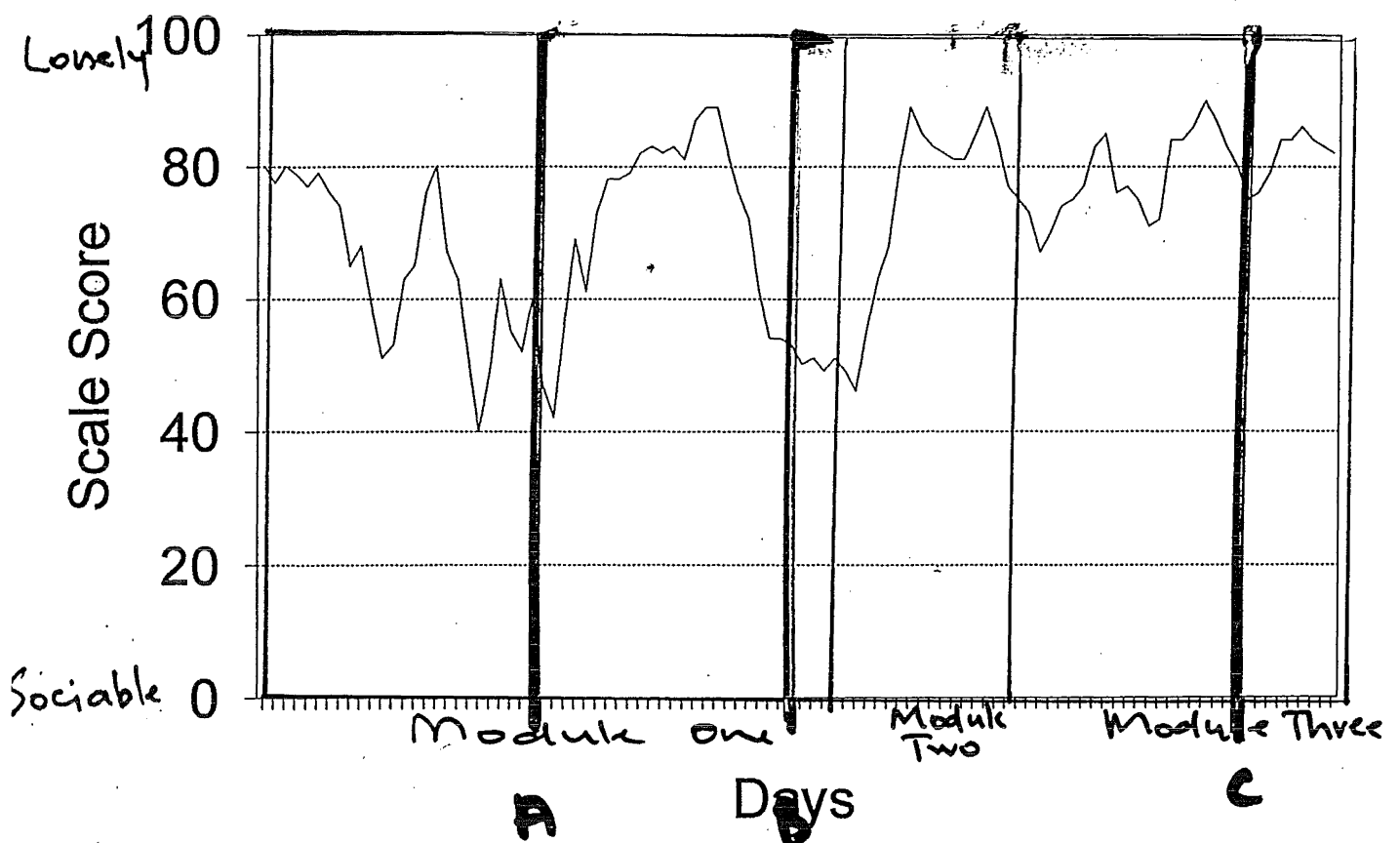


Hot seat

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 12.

Subject 12 Scale 2

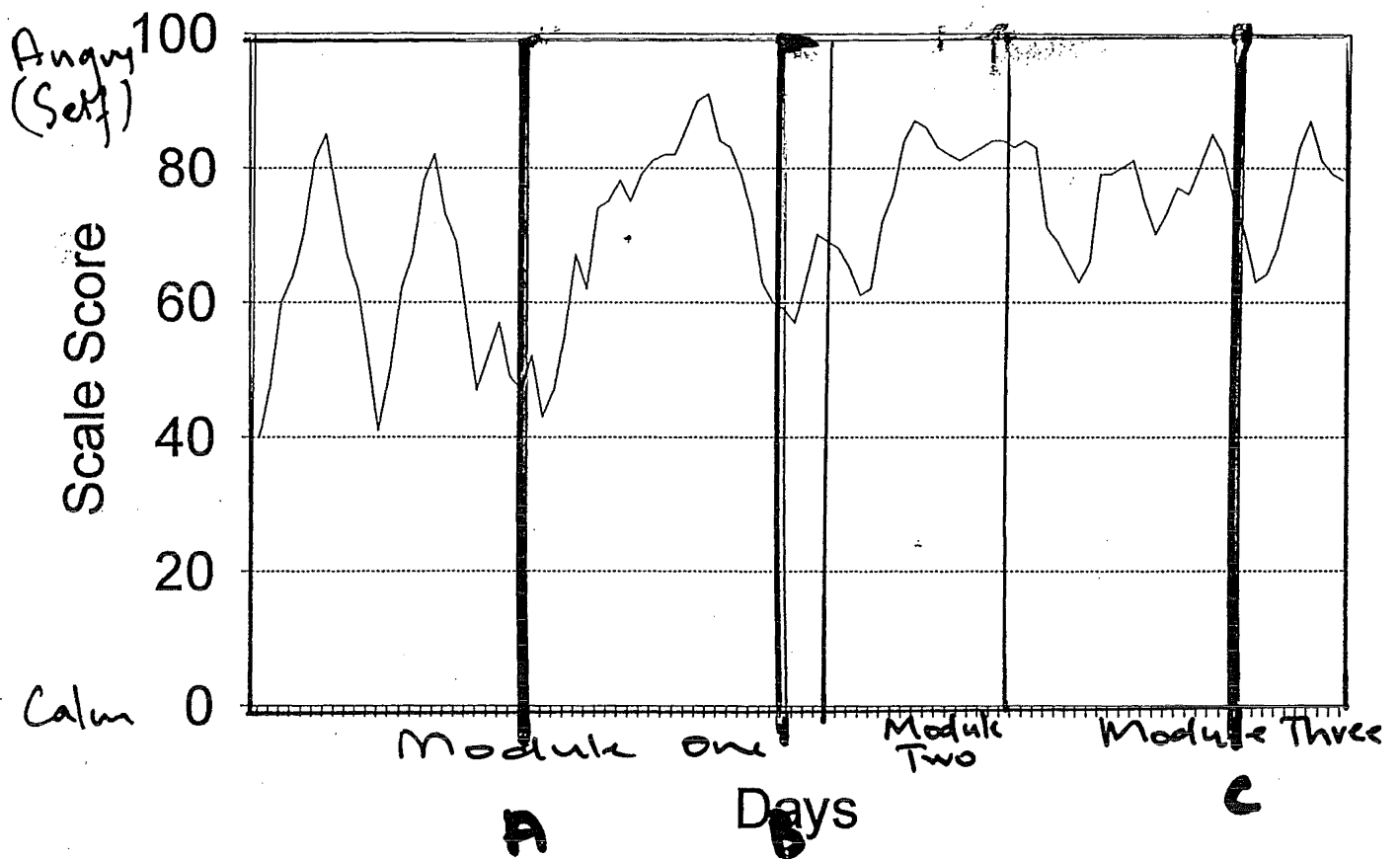


Hot seat

- A Cognitive Distortions offence Cycle 1
- B Cognitive Distortions offence Cycle 2
- C Victim Impact / Empathy.

Subject 12.

Subject 12 Scale 3

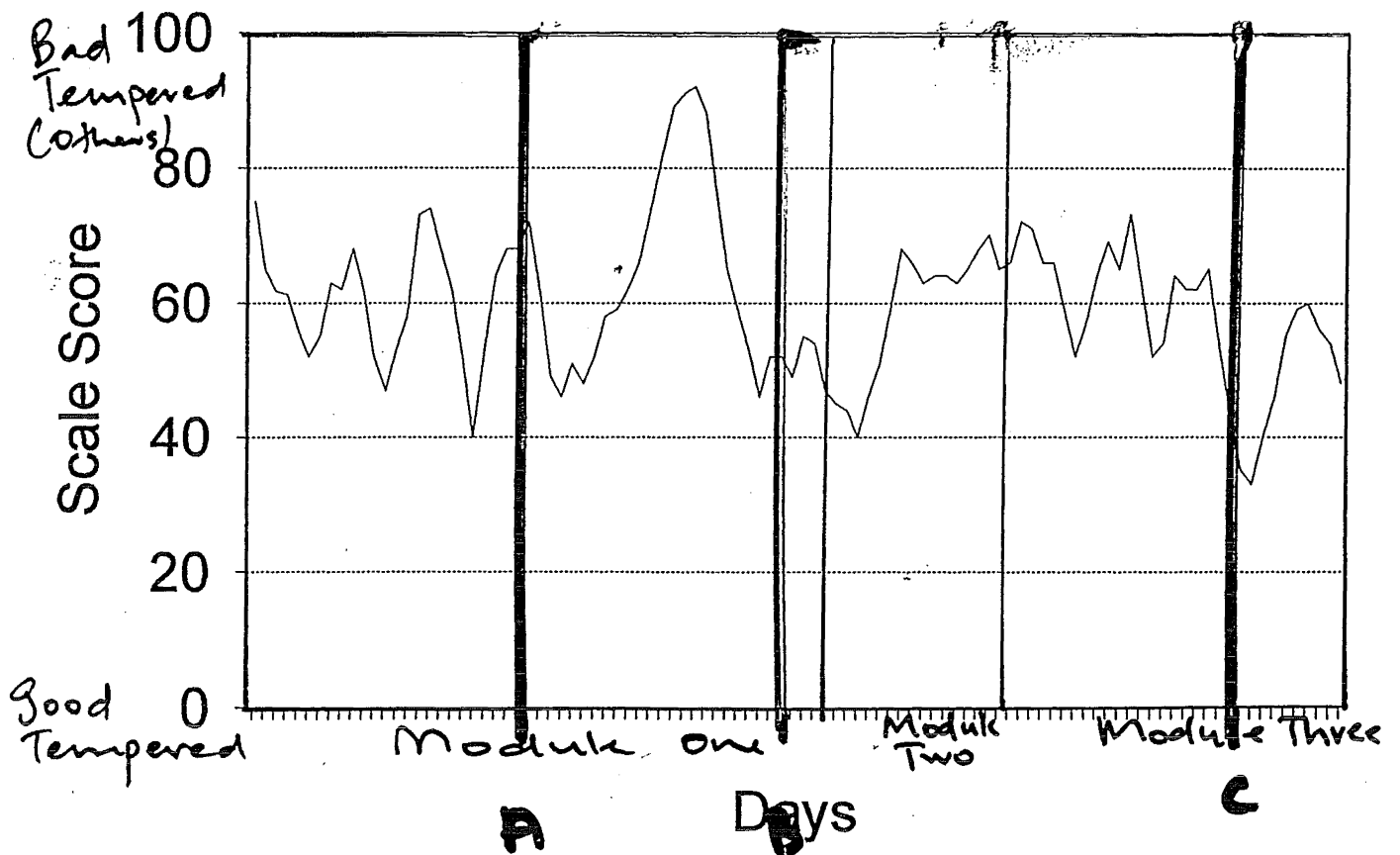


Hot seat

- A Cognitive Distortions offence Cycle 1
- B Cognitive Distortions offence Cycle 2
- C Victim Impact / Empathy.

Subject 12.

Subject 12 Scale 4

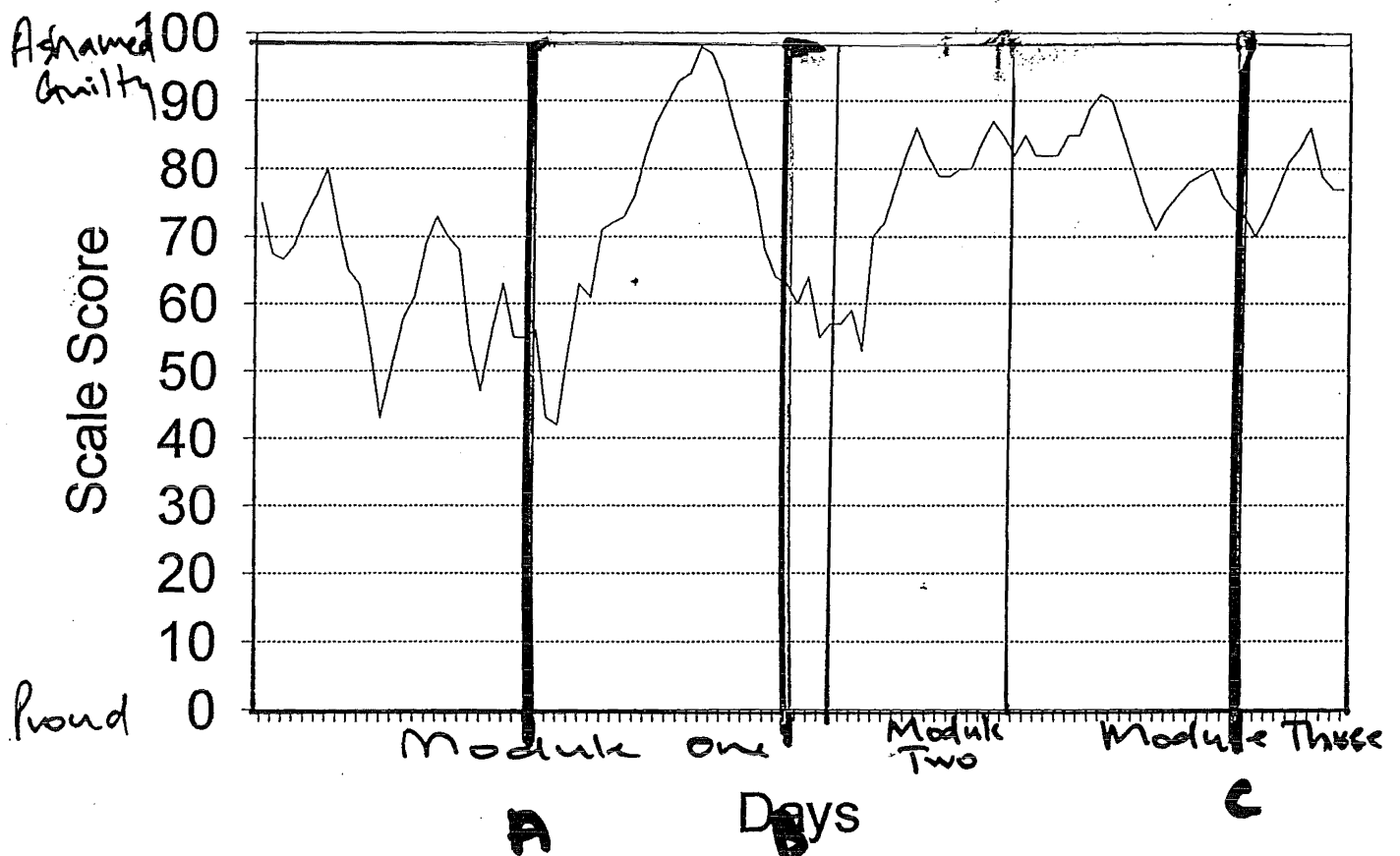


Hot seat

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 12.

Subject 12 Scale 5

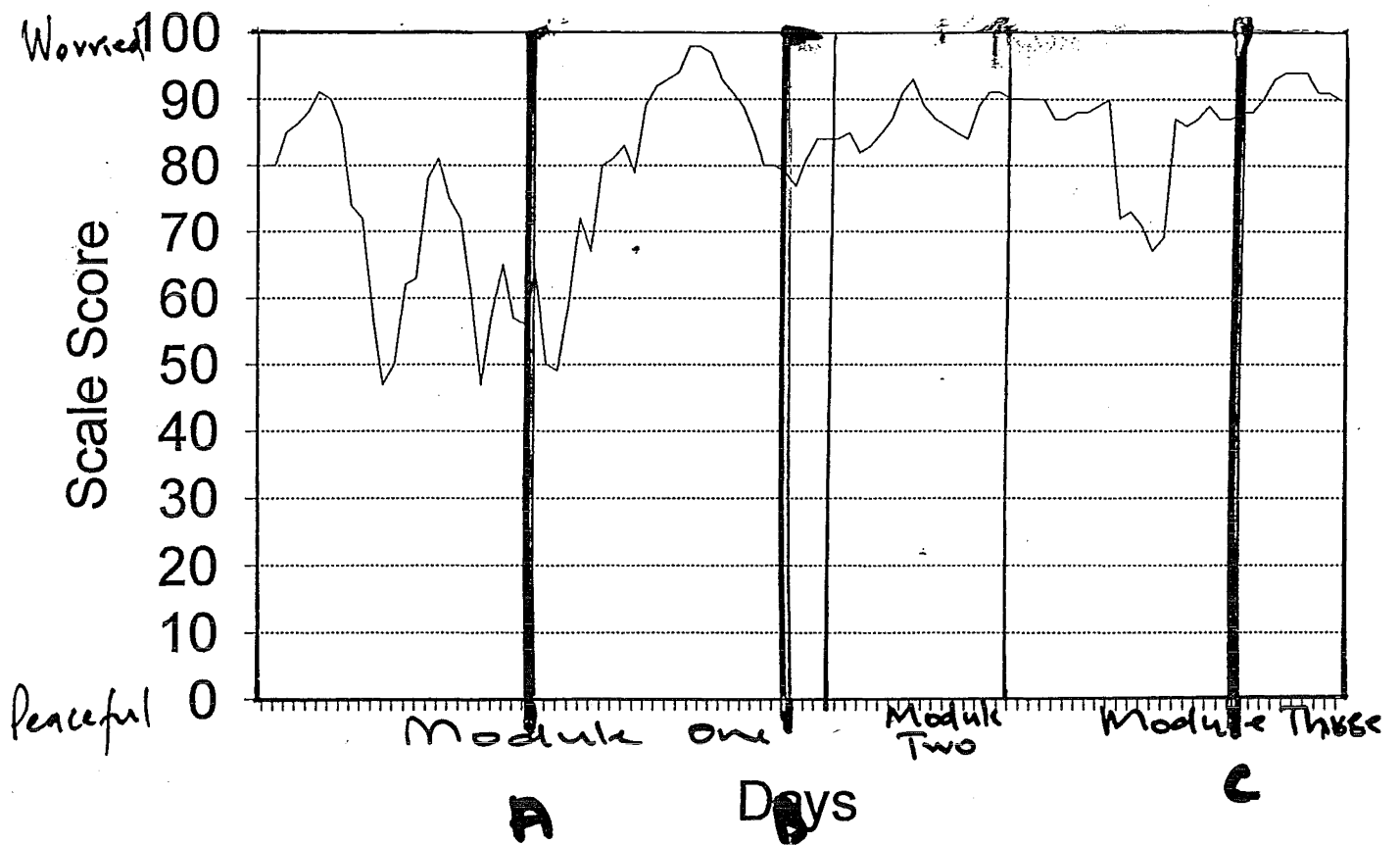


Hot seat

- A Cognitive Distortions Offence Cycle 1
- B Cognitive Distortions Offence Cycle 2
- C Victim Impact / Empathy.

Subject 12.

Subject 12 Scale 6

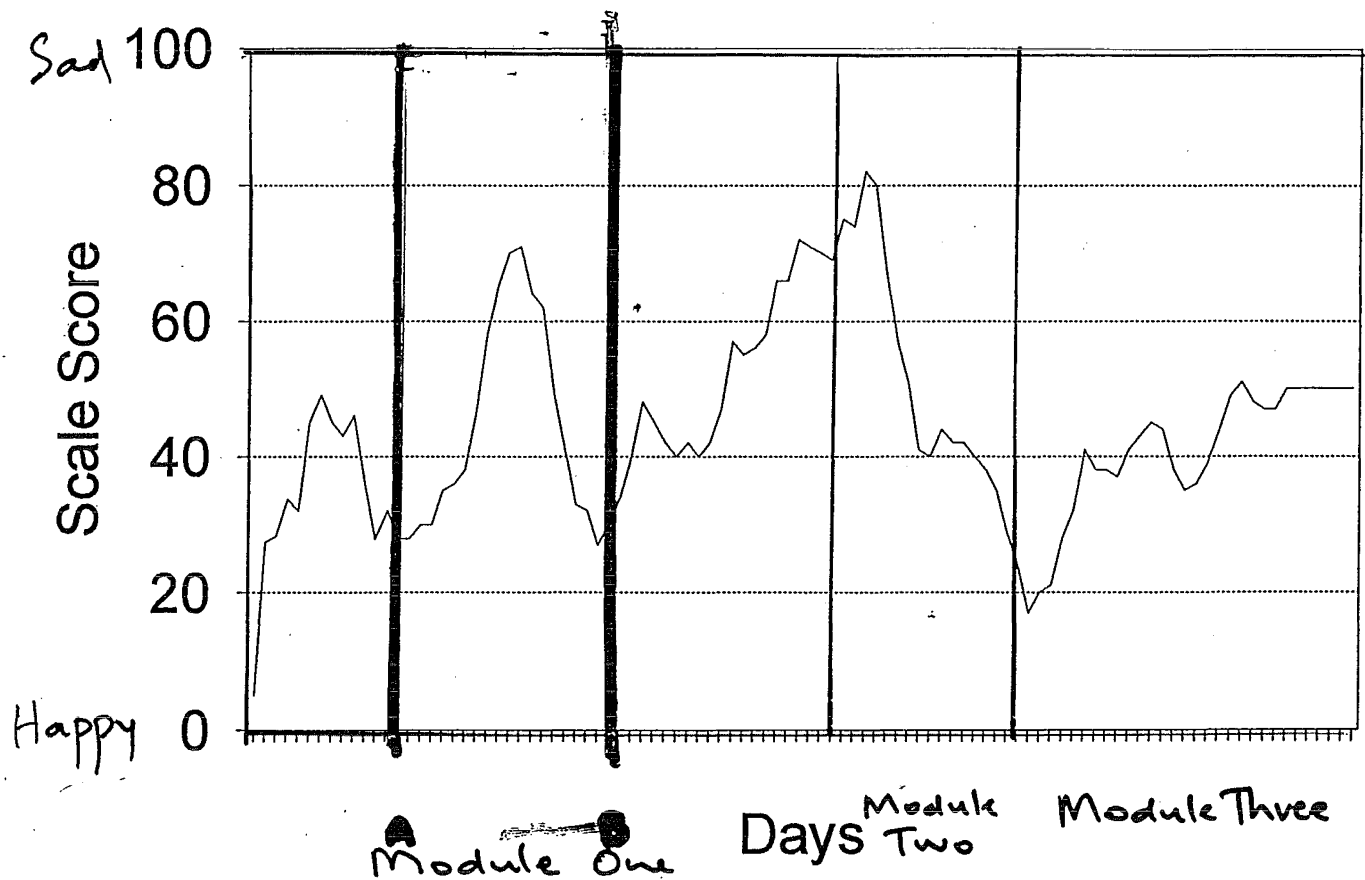


Hot seat

- A Cognitive Distortions offence Cycle 1
- B Cognitive Distortions offence Cycle 2
- C Victim Impact / Empathy.

Subject 13

Subject 13 Scale 1

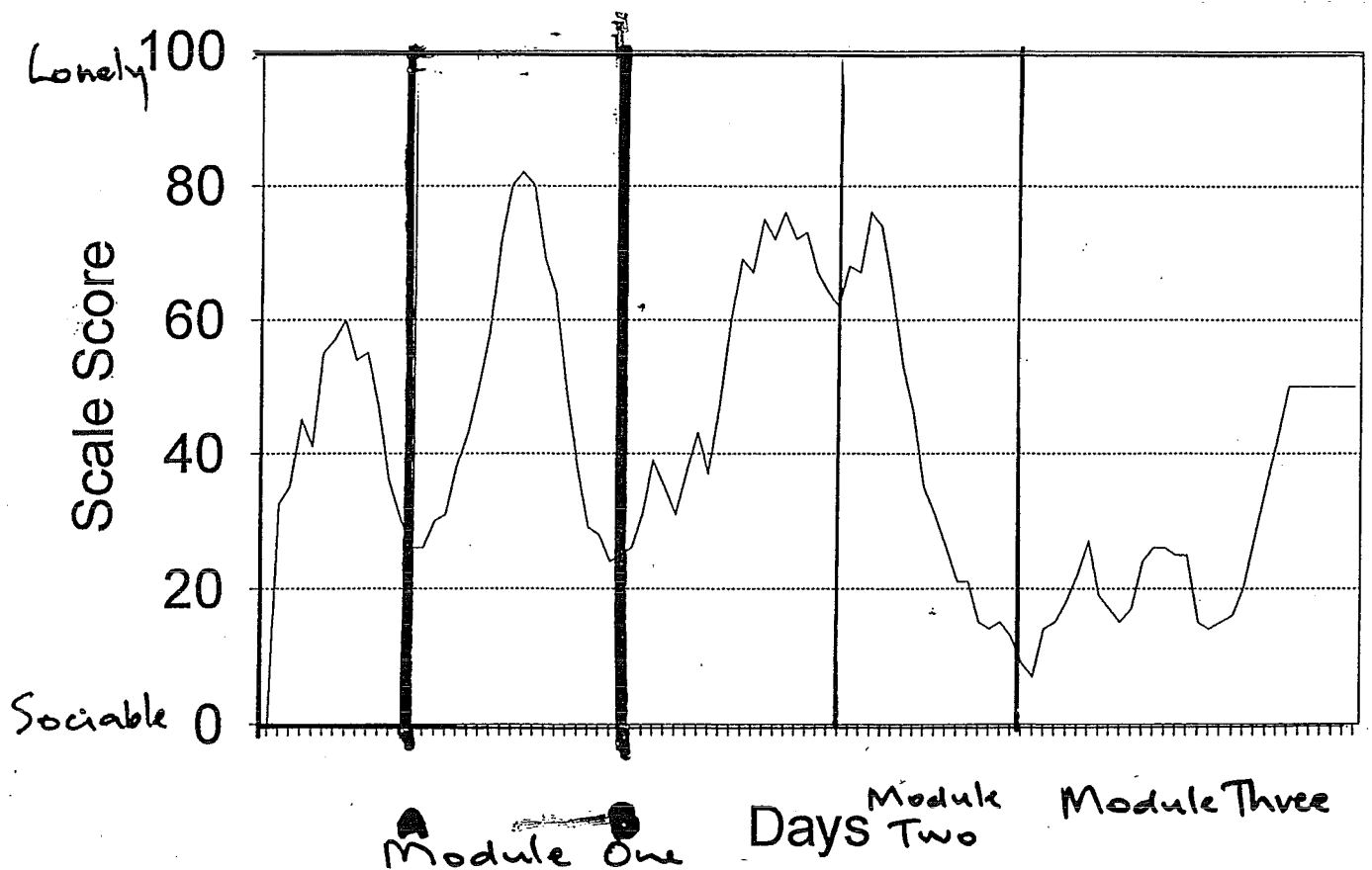


"Hotseat"

- A Cognitive Distortions Offence Cycle One
- B Cognitive Distortions Offence Cycle two
- C Not Recorded

Subject 13

Subject 13 Scale 2

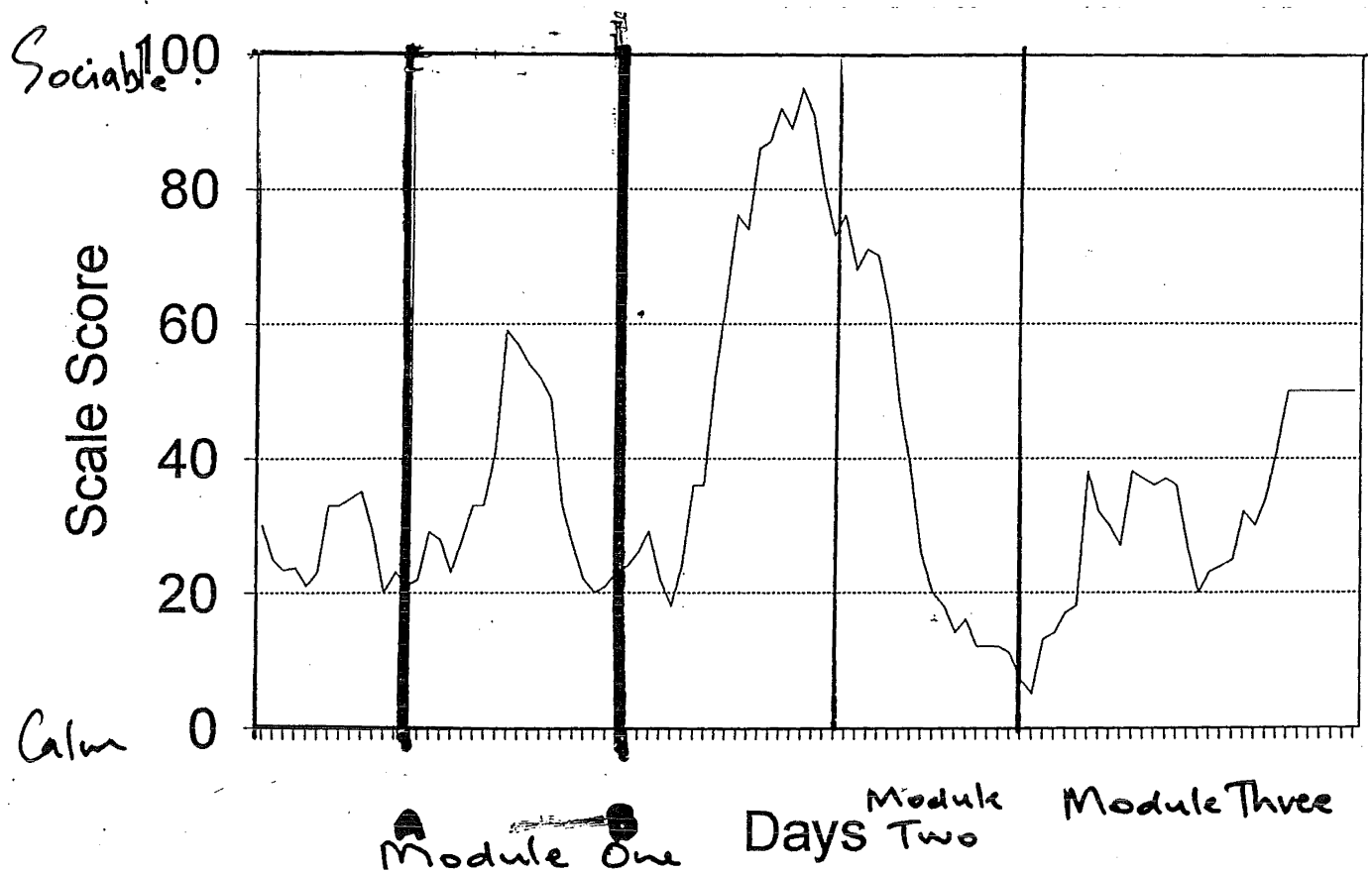


"Hotseat"

- A Cognitive Distortions Offence Cycle One
- B Cognitive Distortions Offence Cycle two
- C Not Recorded

Subject 13

Subject 13 Scale 3

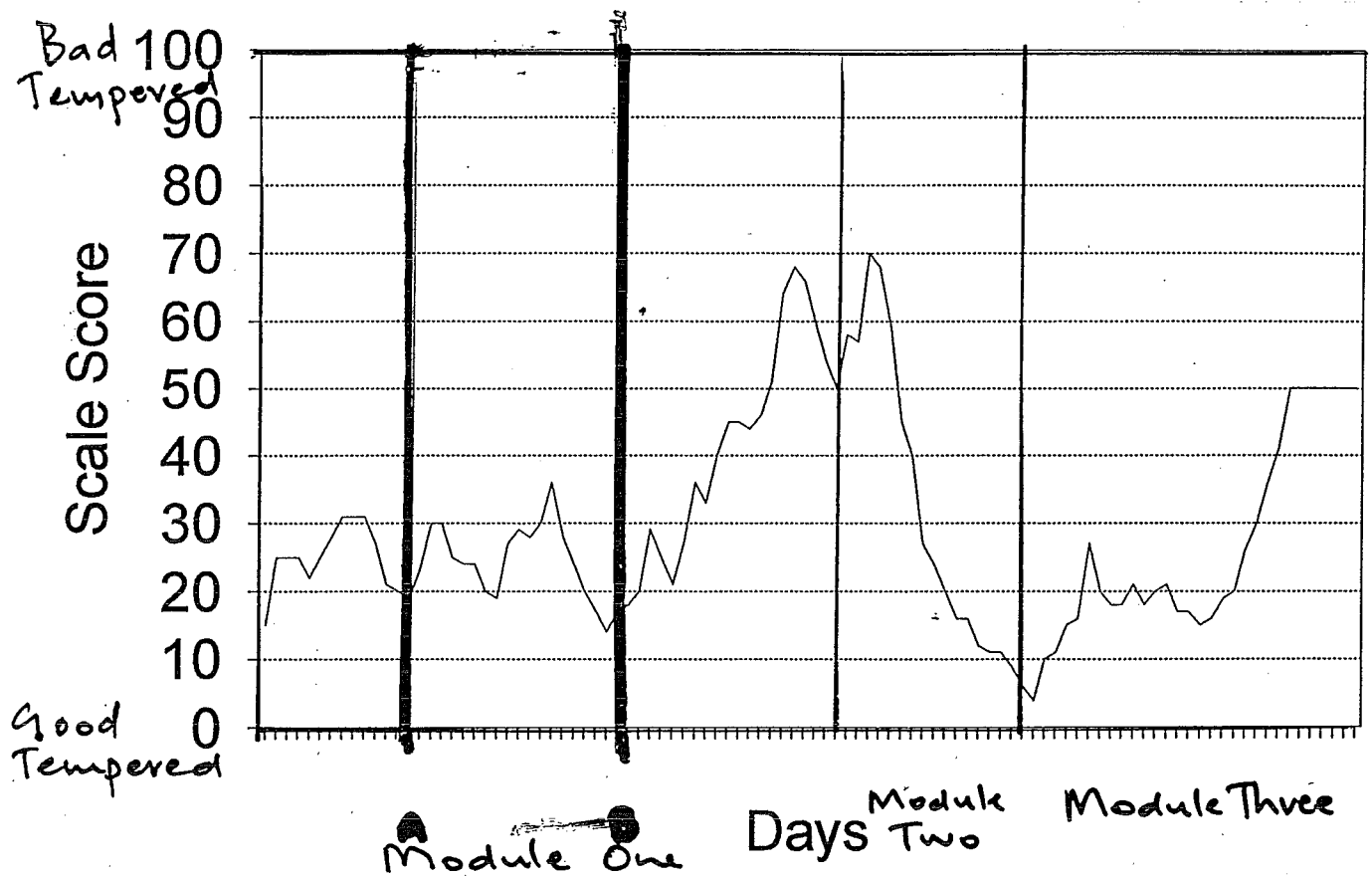


"Hotseat"

- A Cognitive Distortions Offence Cycle One
- B Cognitive Distortions Offence Cycle two
- C Not Recorded

Subject 13

Subject 13 Scale 4

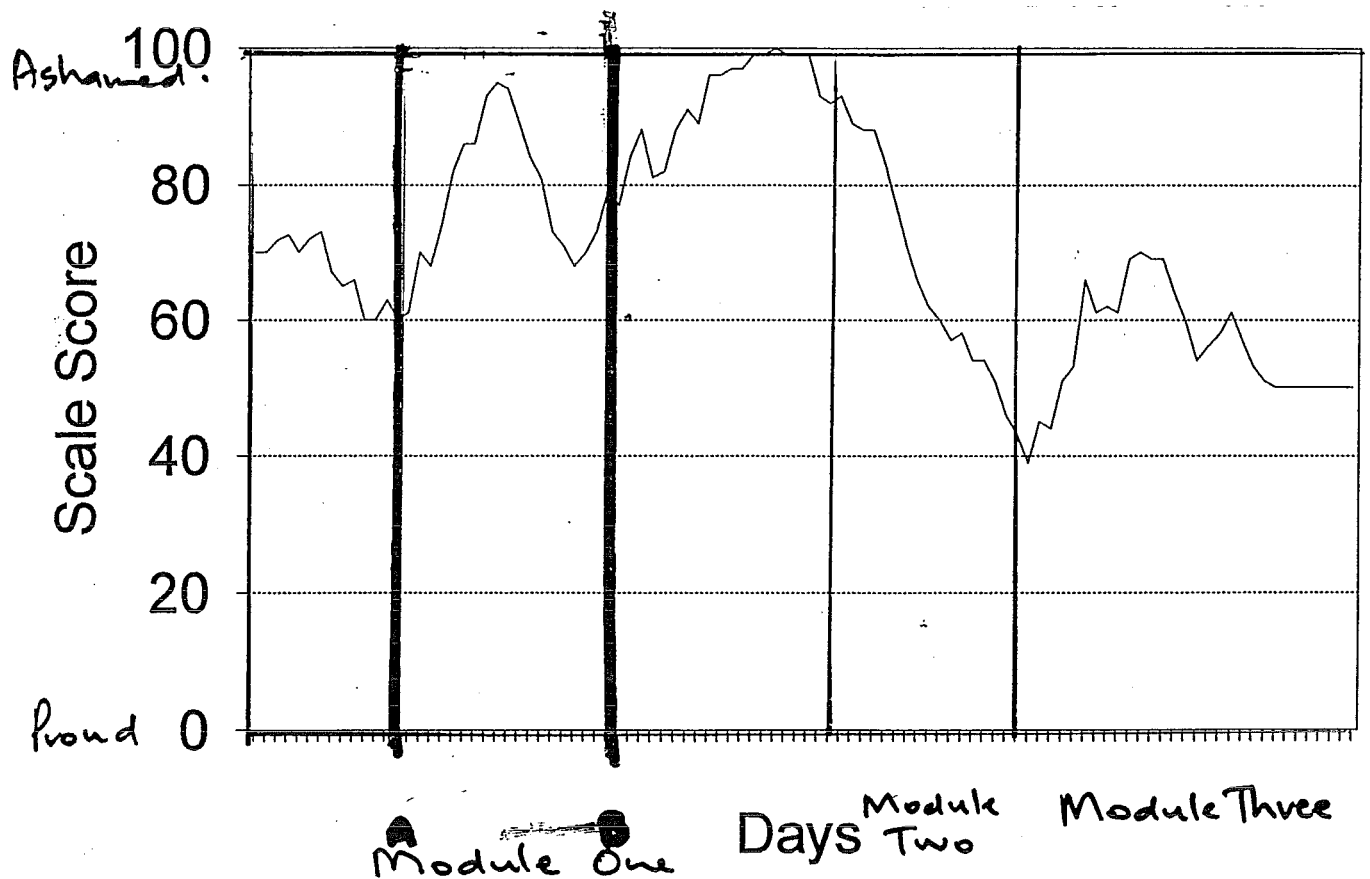


"Hotseat"

- A Cognitive Distortions Offence Cycle One
- B Cognitive Distortions Offence Cycle two
- C Not Recorded

Subject 13

Subject 13 Scale 5

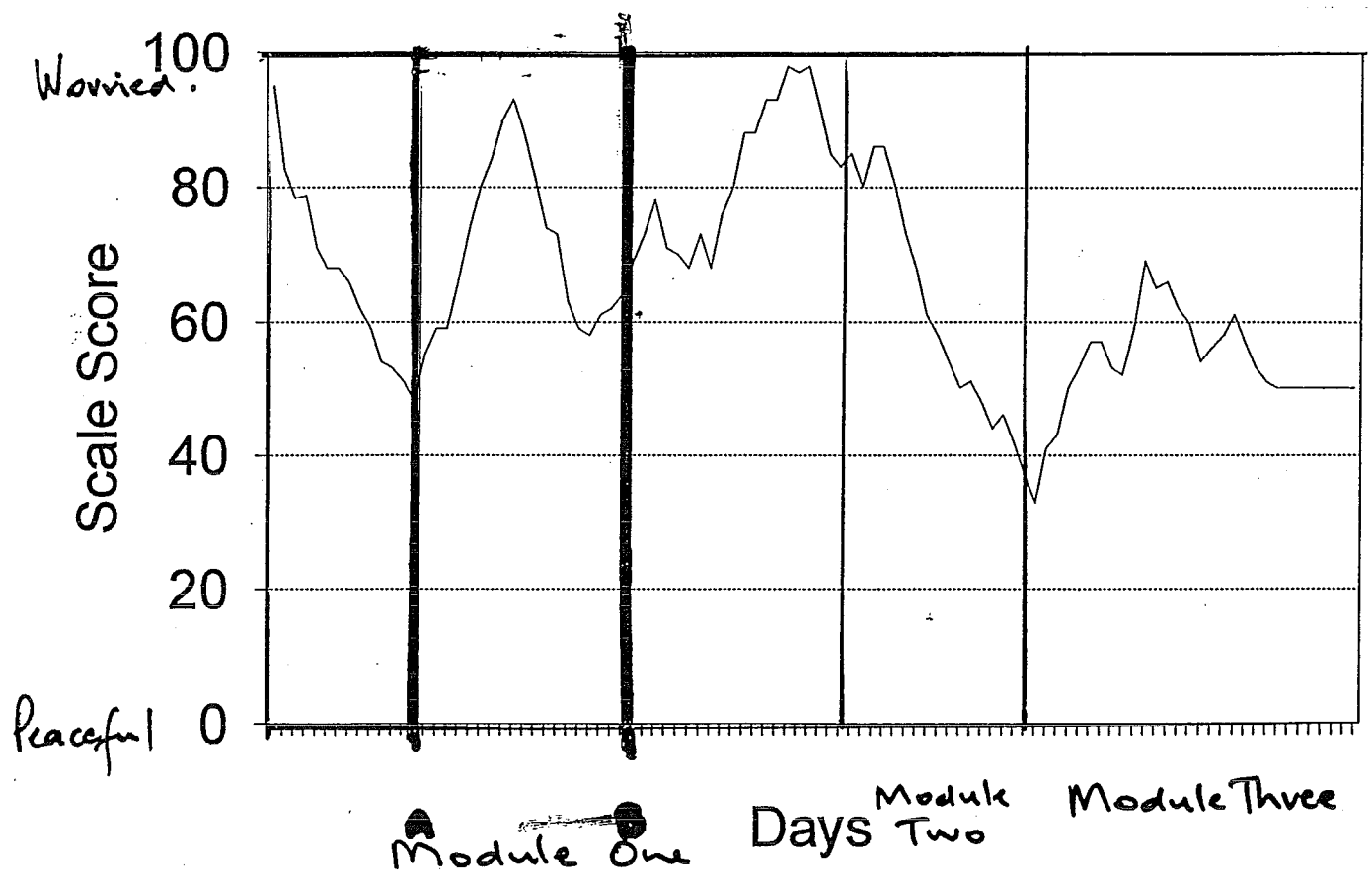


"Hotseat"

A	Cognitive Distortions	Offence Cycle One
B	Cognitive Distortions	Offence Cycle two
C	Not Recorded	

Subject 13

Subject 13 Scale 6

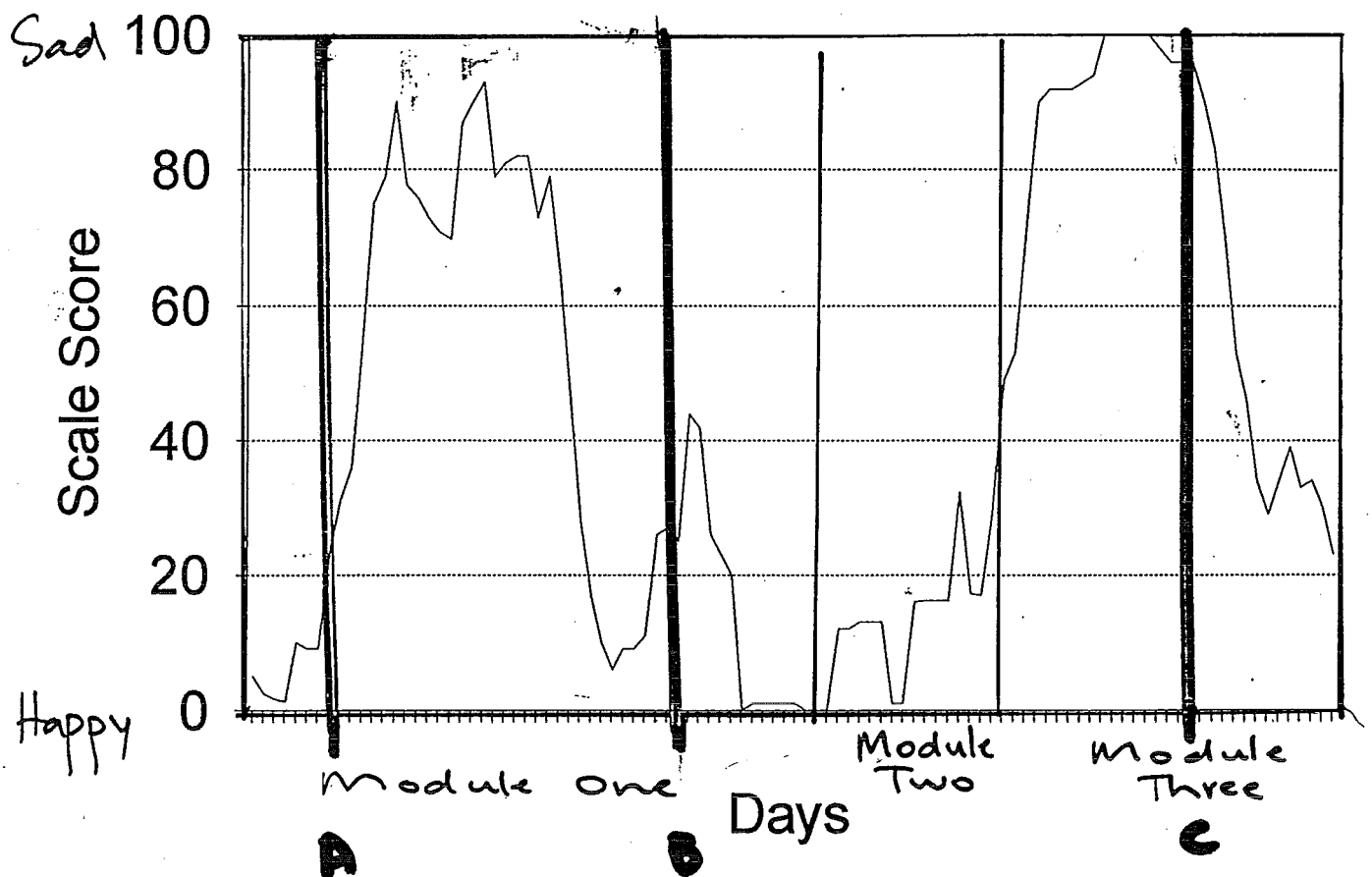


"Hotseat"

- A Cognitive Distortions Offence Cycle One
- B Cognitive Distortions Offence Cycle two
- C Not Recorded

Subject 14

Subject 14 Scale 1

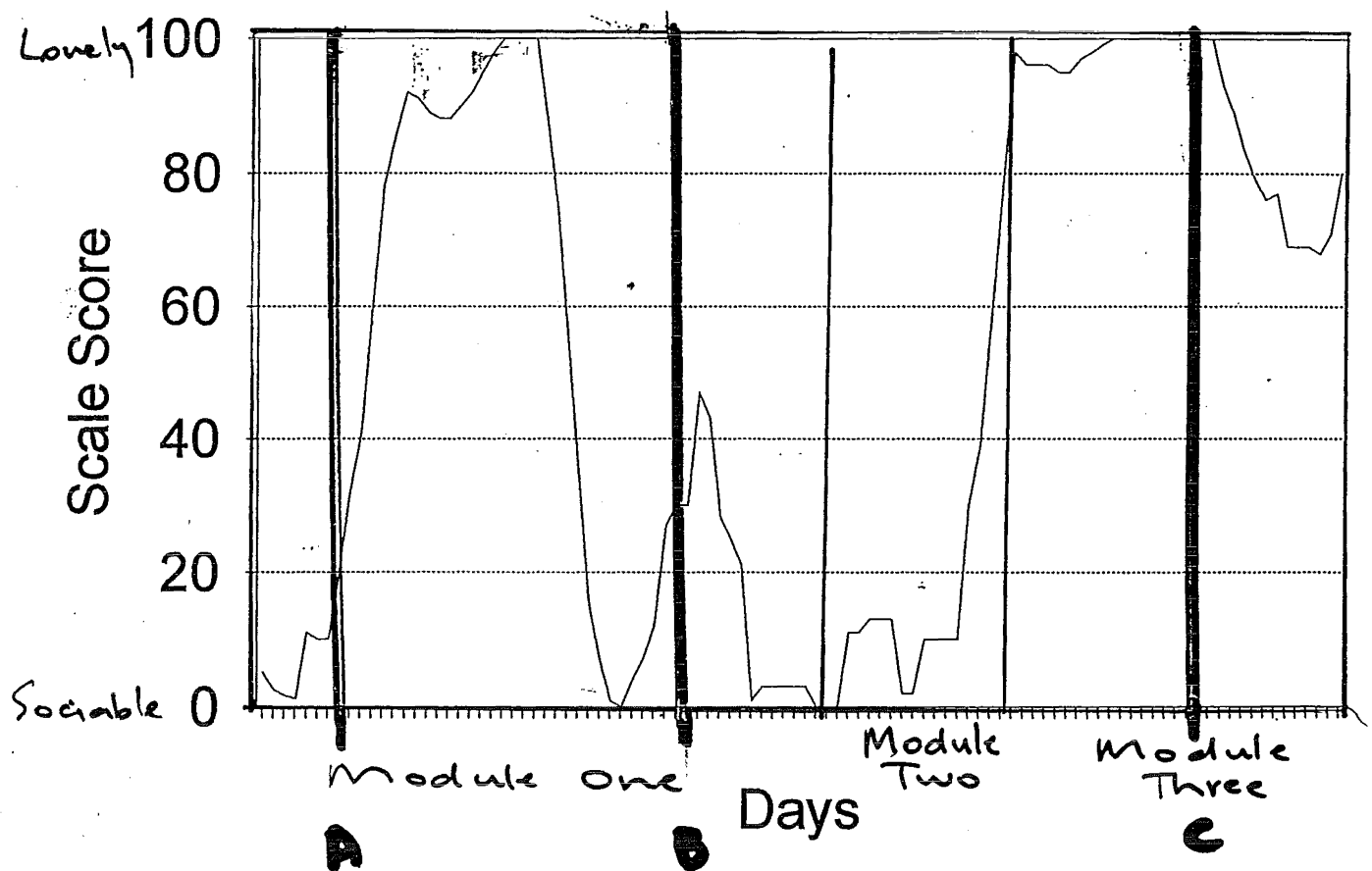


"Hotseat"

A
B
C

Subject 14

Subject 14 Scale 2



"Hotseat"

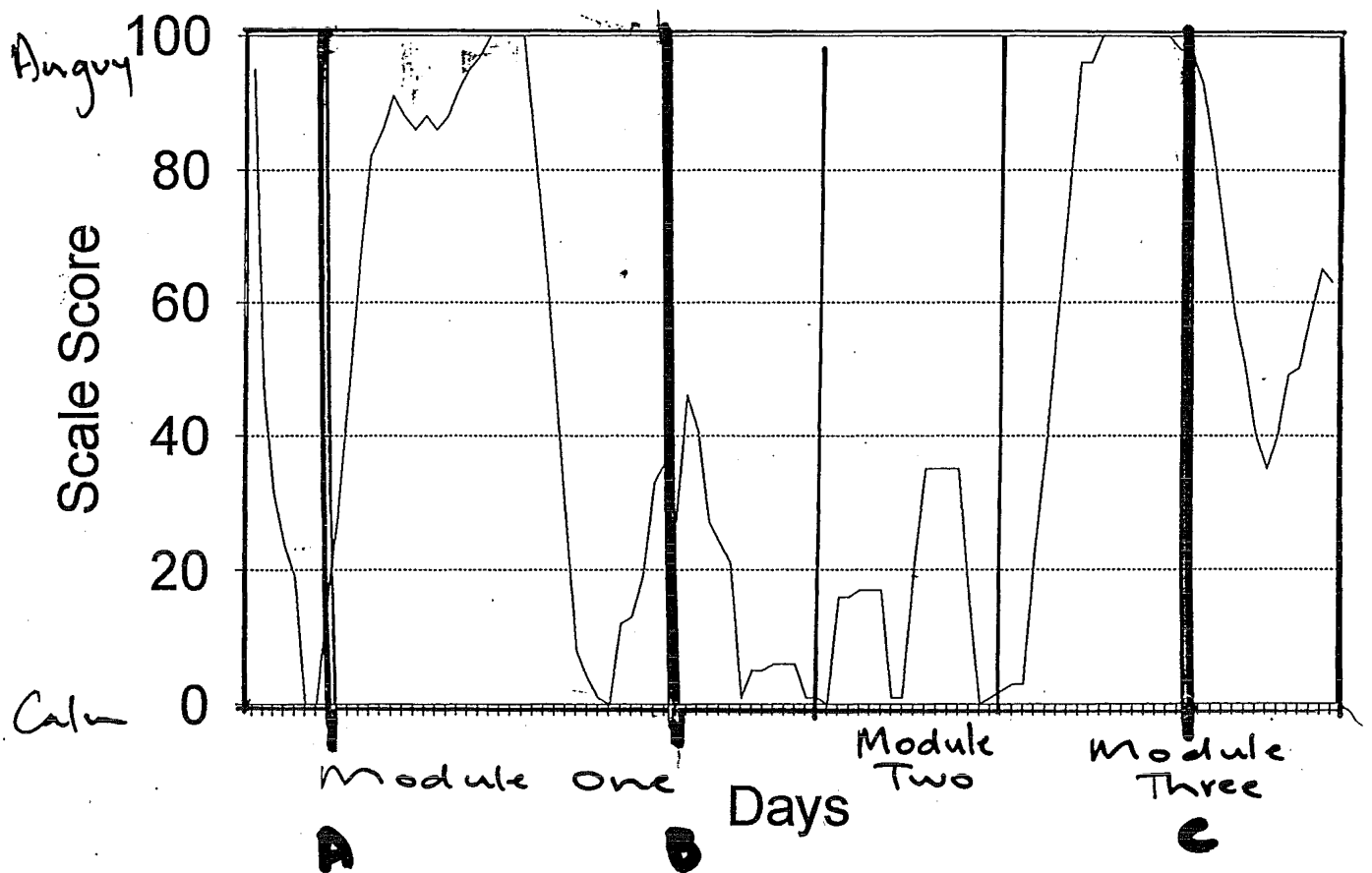
A

B

C

Subject 14

subject 14 Scale 3

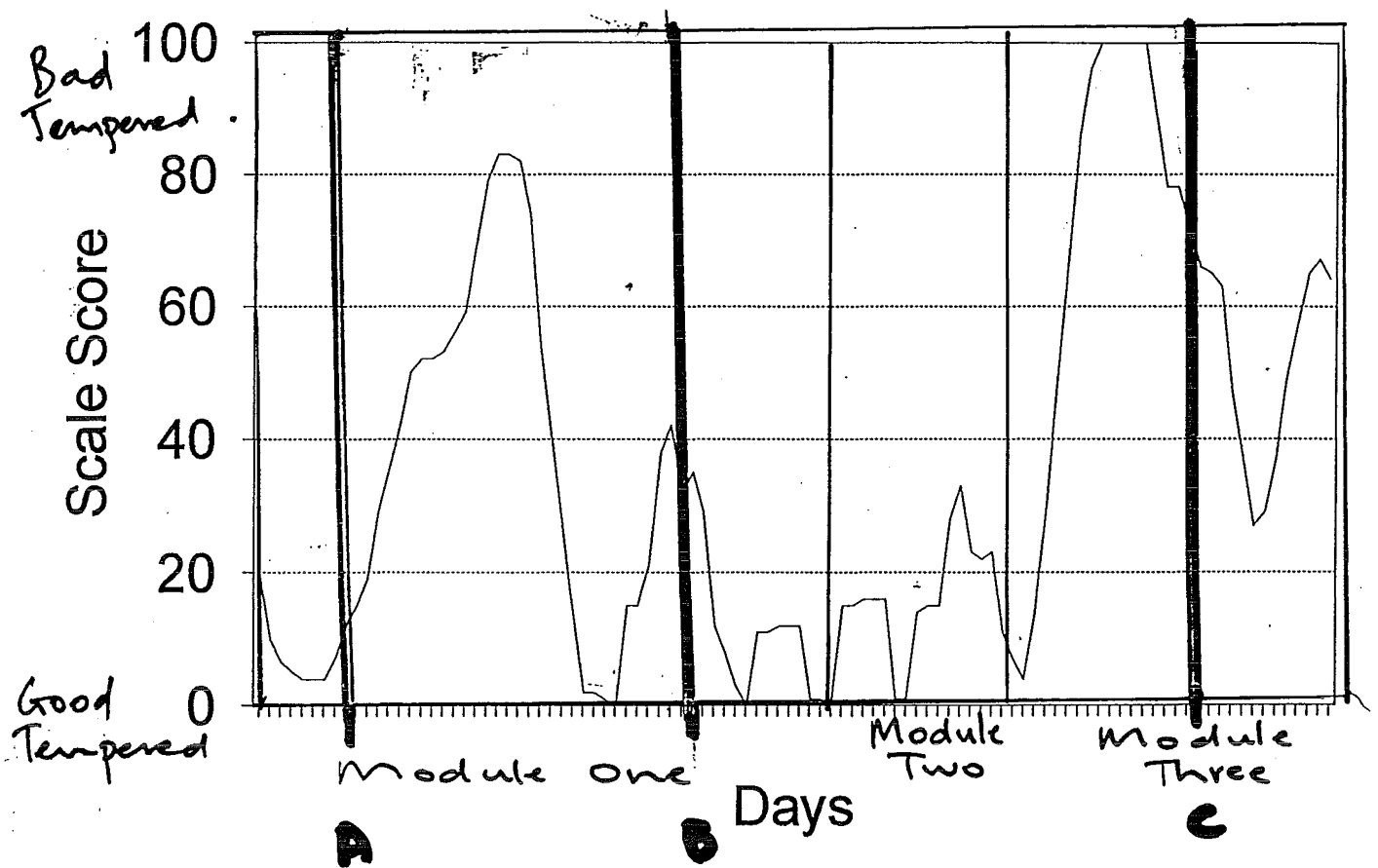


"Hotseat"

A
B
C

Subject 14

Subject 14 Scale 4



"Hotseat"

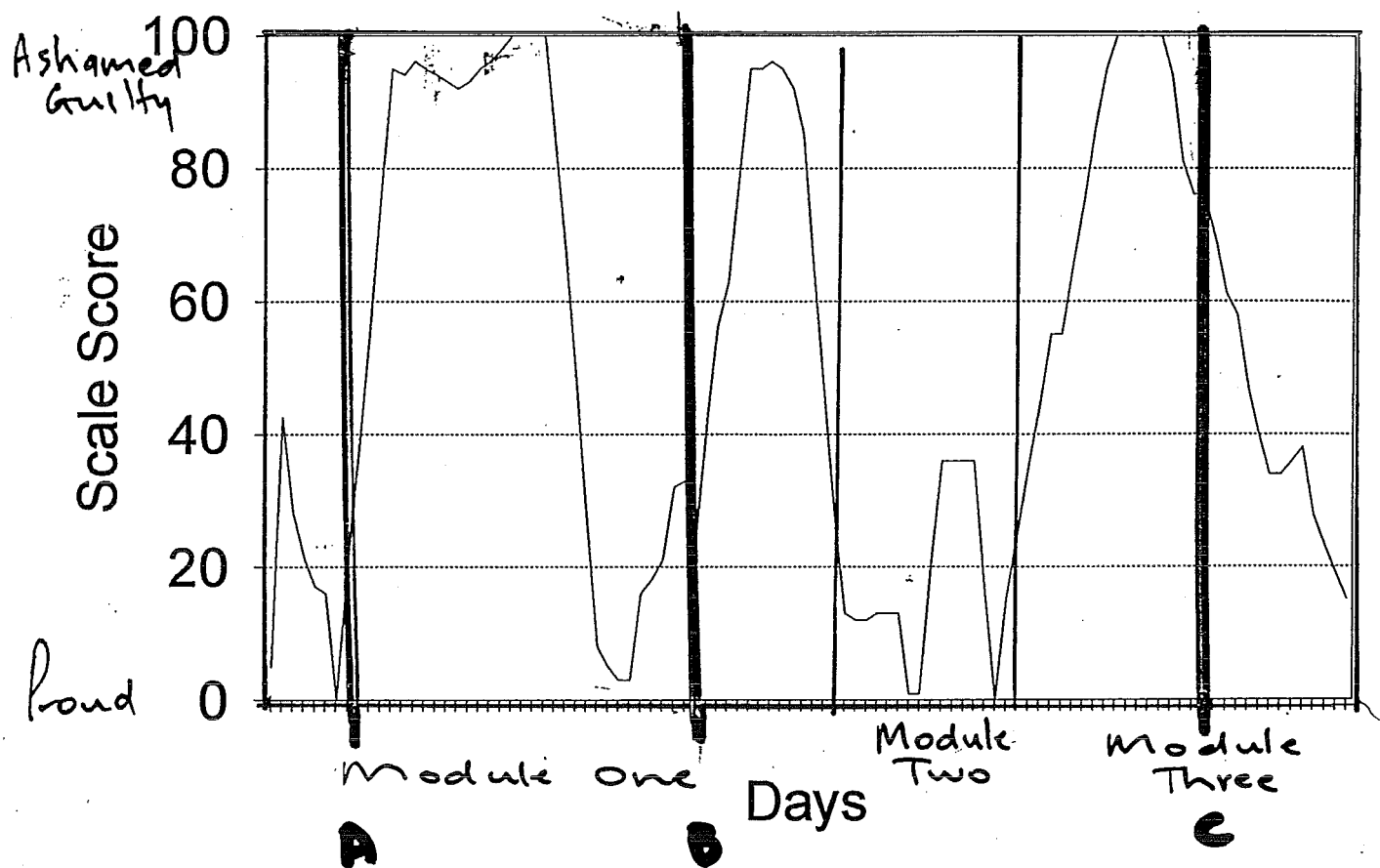
A

B

C

Subject 14

Subject 14 Scale 5



a Hofseant "

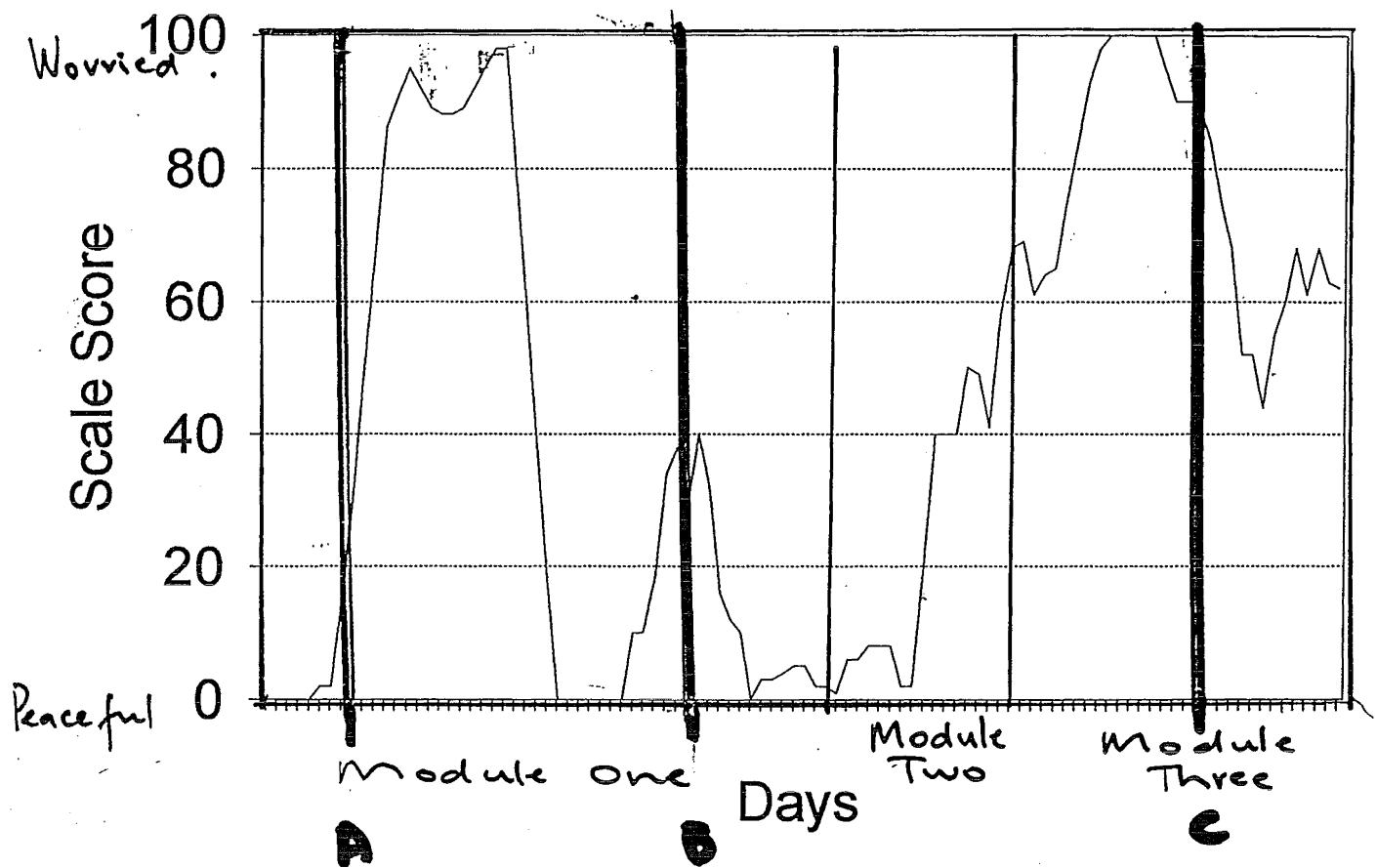
A

B

2

Subject 14

Subject 14 Scale 6



"Hotseat"

A
B
C